

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

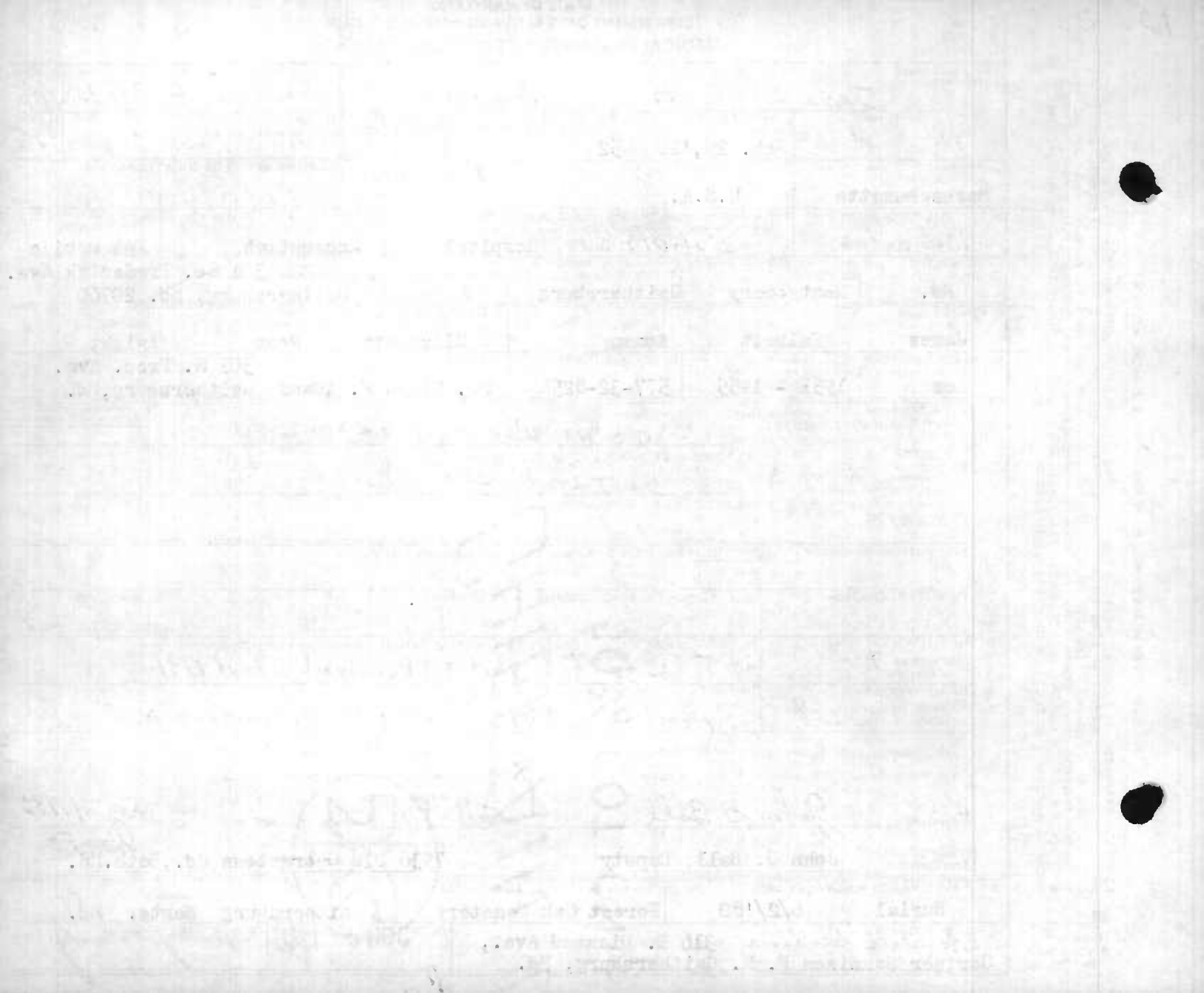
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8013179		
1. FOR STATE REGISTRAR		REG. NO.										
1 DECEASED NAME (TYPE OR PRINT) First Middle Last <b>Breda Ostrow Adams</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>5 7 '80</b>			2b. HOUR <b>1:00</b> M				
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 23, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS <b>12</b> MONTHS <b>0</b> DAYS		7. UNDER 24 HRS HOURS MIN. <b>0</b> HOURS <b>0</b> MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.						
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Collingswood Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Physical therapist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6120 Robinwood Road</b>	
14. FATHER'S NAME First Middle Last <b>Joseph Rosenberg</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Dena Mazer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-88-5976</b>		17. INFORMANT ADDRESS <b>Bethesda, Maryland</b> <b>Dr. Bernard Ostrow 6120 Robinwood Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASBO, gangrene of leg,</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>C.V.A.</b> <b>per-throm vascular disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Colours.</b> <b>1 year</b> <b>2 years</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diphtheria, Recurrent upper respiratory Infection &amp; Strain</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>1978</b>		CITY OR TOWN <b>Now</b>		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>3-2-80</b> , 19 <b>80</b> , to <b>Now</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>3-2-80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)												
22b. SIGNATURE <b>John A. Galt</b>					DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5-7-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John A. GALT</b>					22e. ADDRESS <b>5225 Rock Hill Rd. Bethesda, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-9-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Adas Israel Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Washington, D. C.</b> COUNTY <b>D. C.</b> STATE					
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisconsin Ave., N. W., Washington, D. C.</b>					25. DATE RECEIVED BY REGISTRAR <b>MAY 10 1980</b>							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13180	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Jessie H Adams</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5-31-80</b>		2b. HOUR <b>10 AM</b>			
3. SEX <b>M</b>	4. RACE <b>W.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 25, '28</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>52</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD <b>May 31, 1980</b>		2d. HOUR <b>10 AM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto mobile</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>301 So. Frederick Ave. Gaithersburg, Md. 20760</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Talbott Adams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Ross Knight</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1951 - 1955</b>		17. INFORMANT <b>Mrs. Diane F. Adams</b>		ADDRESS <b>301 S. Fred. Ave. Gaithersburg, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot Wound of Head.</b> 9552 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Self inflicted.</b> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR <b>7:30 P.M. 5-30-1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Shot self in Head. 22 cal rifle.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>301 S. Frederick Ave Gaithersburg Mont. Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>May 31, 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, Deputy</b>				ADDRESS <b>7936 Old Georgetown Rd., Beth. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/2/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Gaithersburg Montg. Md.</b>			
24. FUNERAL DIRECTOR <b>Gartner Sandison</b>						ADDRESS <b>316 E. Diamond Ave., Gaithersburg, Md.</b>		25a. DATE RECEIVED BY REGISTRAR <b>JUN 5 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORMS PM, 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13181 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST <i>Margaret E. Adams</i>										20. DATE KNOWN OF DEATH MONTH DAY YEAR <i>May 1 1980</i>			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 18 1948</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>31 YRS.</i>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN <i>4 YRS.</i>		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN <i>4 YRS.</i>		21. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>May 1 1980</i>											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.											
10. CITY OR TOWN OF DEATH <i>Sil Spg</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bel Pre Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>-----</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>											
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Sykesville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>Springfield State Hospital</i>															
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles David Adams</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret Myers</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>214-07-6373-C</i>											
17. INFORMANT <i>Charles Adams</i>				ADDRESS <i>526 Franklin St Piqua, Ohio 45356</i>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxiation</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Choking on Food</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-----</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>911-</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>Parkinson's Dis.</i>																							
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>-----</i>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>Choked on Food</i>				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <i>6:15 P.M. 5-2-80</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Choked on Food</i>															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Nursing Home</i>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Bel Pre Rd. Sil Spg. Montg. Md</i>															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <i>M.D.</i>				MEDICAL EXAMINER <i>Dep</i>				DATE SIGNED <i>May 2 1980</i>											
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, M.D.</i>				ADDRESS <i>Silver Springs, Md.</i>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>May 7, 1980</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cumberland Allegany Maryland</i>											
24. FUNERAL DIRECTOR NAME <i>Silcox-Merritt Funeral Service, Cumberland, Md</i>				ADDRESS <i>404 Decatur St</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 12 1980</i>				25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>											

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13182	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>William Wilson Adams</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <b>5-26-80</b>		2b. HOUR <b>A</b>		MONTH DAY YEAR	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 30 1904</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>76 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD <b>May 26 1980</b>		2d. HOUR <b>2P</b>		MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD				
10. CITY OR TOWN OF DEATH <b>Rockville</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>13206 Parkland Drive</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>clerk</b>		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>13206 Parkland Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William S. Adams</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura P. Pfeiffer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT ADDRESS <b>Frank E. Fink same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John B. Ball</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>May 26 1980</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>				ADDRESS <b>7936 Old Georgetown Rd Beth. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>5/27/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>						25a. DATE RECD. BY REGISTRAR <b>JUN 2 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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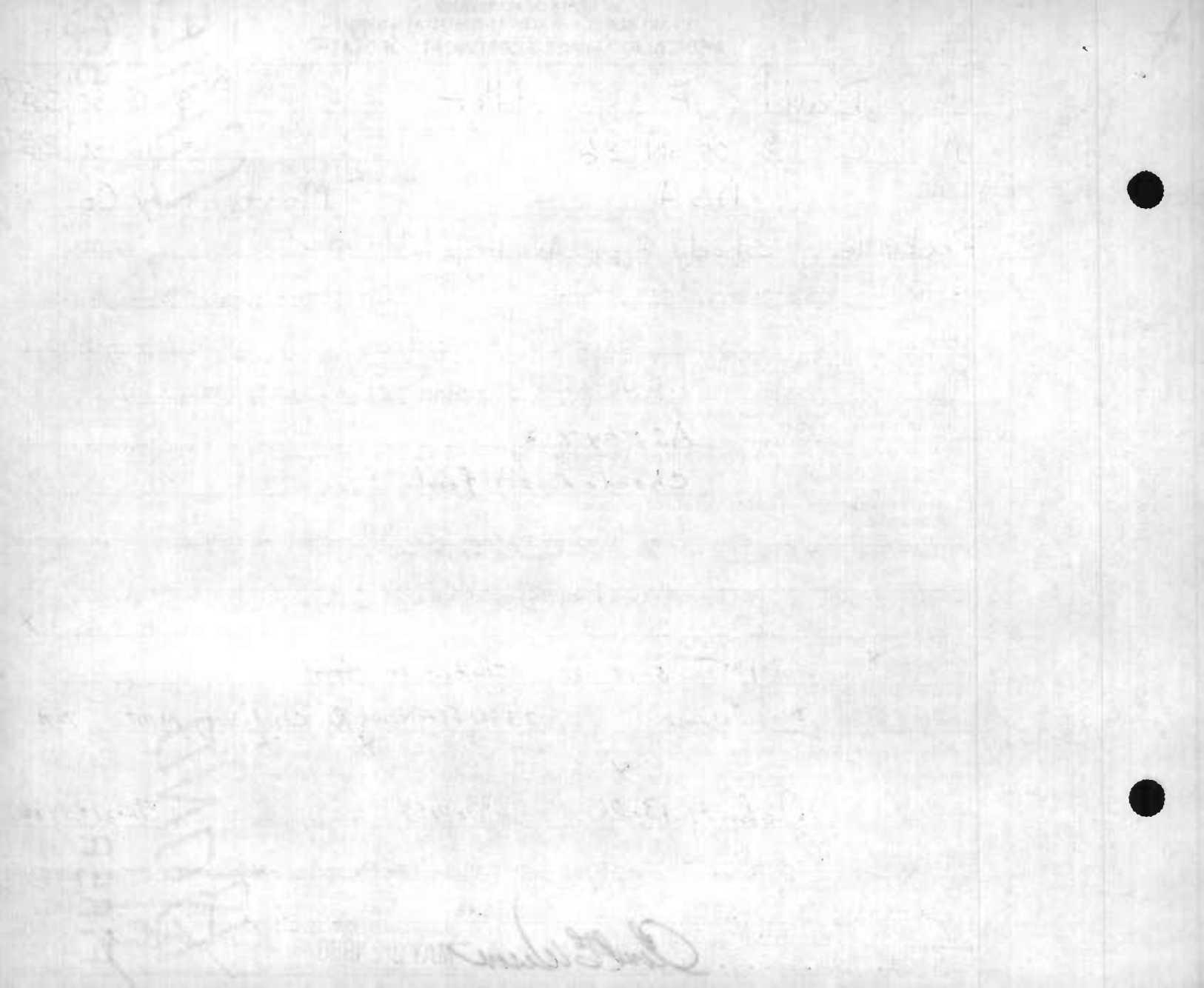
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 13183					
1. FOR STATE REGISTRAR												2b. DATE KNOWN OF DEATH		MONTH DAY YEAR		2c. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David F Adler												MATED <input type="checkbox"/>		5 18 80		3 27 PM	
3. SEX m		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 3 28 41		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 5 18 80		2d. HOUR 3 27 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.					
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adv. Hospital				12a. USUAL OCCUPATION (FOR MOST OF WORKING LIFE) none				12b. KIND OF BUSINESS OR INDUSTRY none					
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 806 Islington Street,							
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Adler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maxine Burtnick				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 578-56-4696					
16c. ADDRESS (father) Nathan Adler- (same as 13e)																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia. DUE TO, OR AS A CONSEQUENCE OF (b) Choked on food. DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 1 35 P.M. 5-18 1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Choked on food.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home.				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 23801 Frederick Rd. Clark'sburg Mont. Md.									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. DePuty				MEDICAL EXAMINER				DATE SIGNED May 18, 1980					
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, DME				ADDRESS Bethesda, Montgomery, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-20-1980		23c. NAME OF CEMETERY OR CREMATORY Judean Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Clark'sburg Mont. Md.							
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				25a. DATE RECEIVED MAY 22 1980				25b. REGISTRAR'S SIGNATURE									



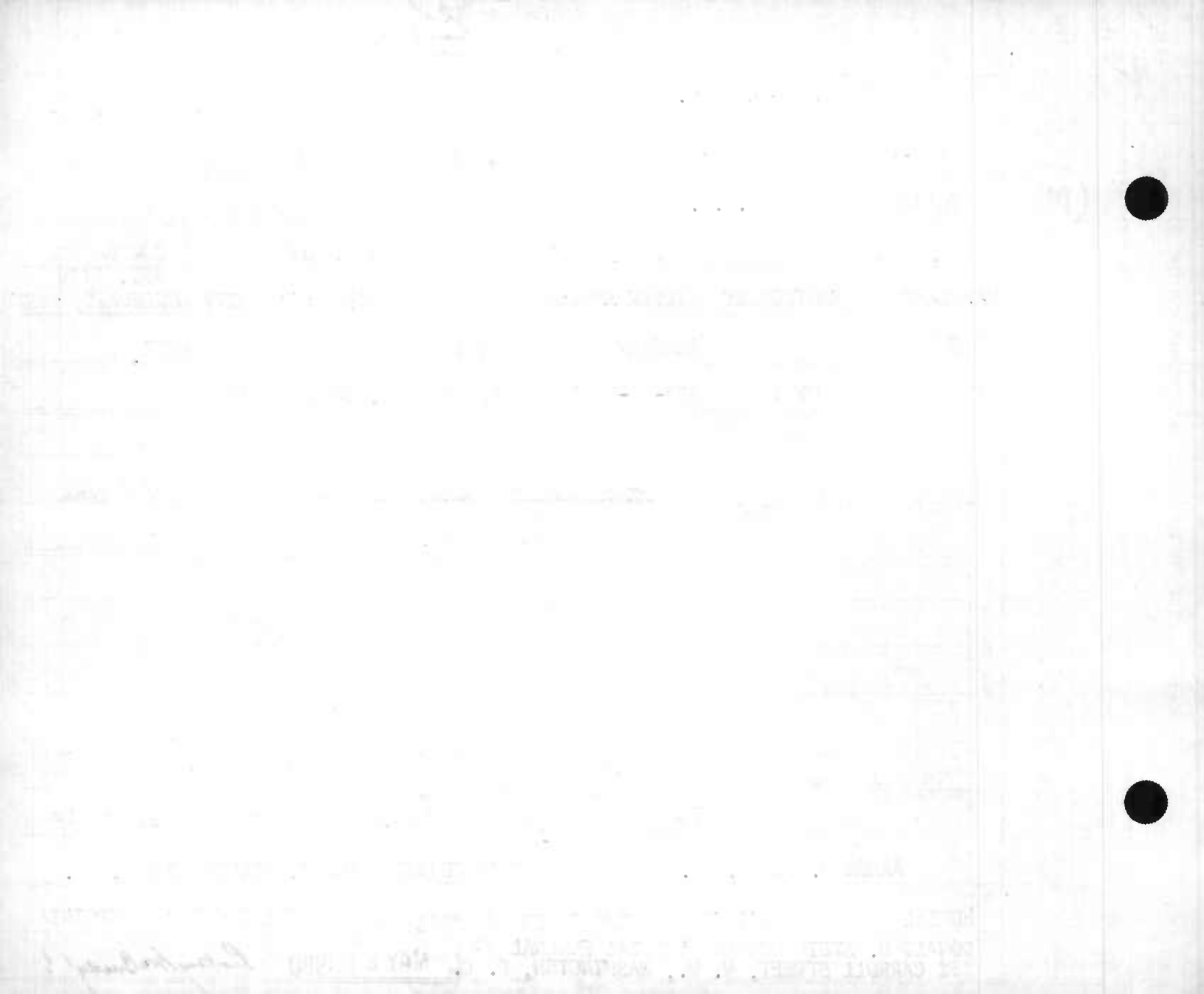
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

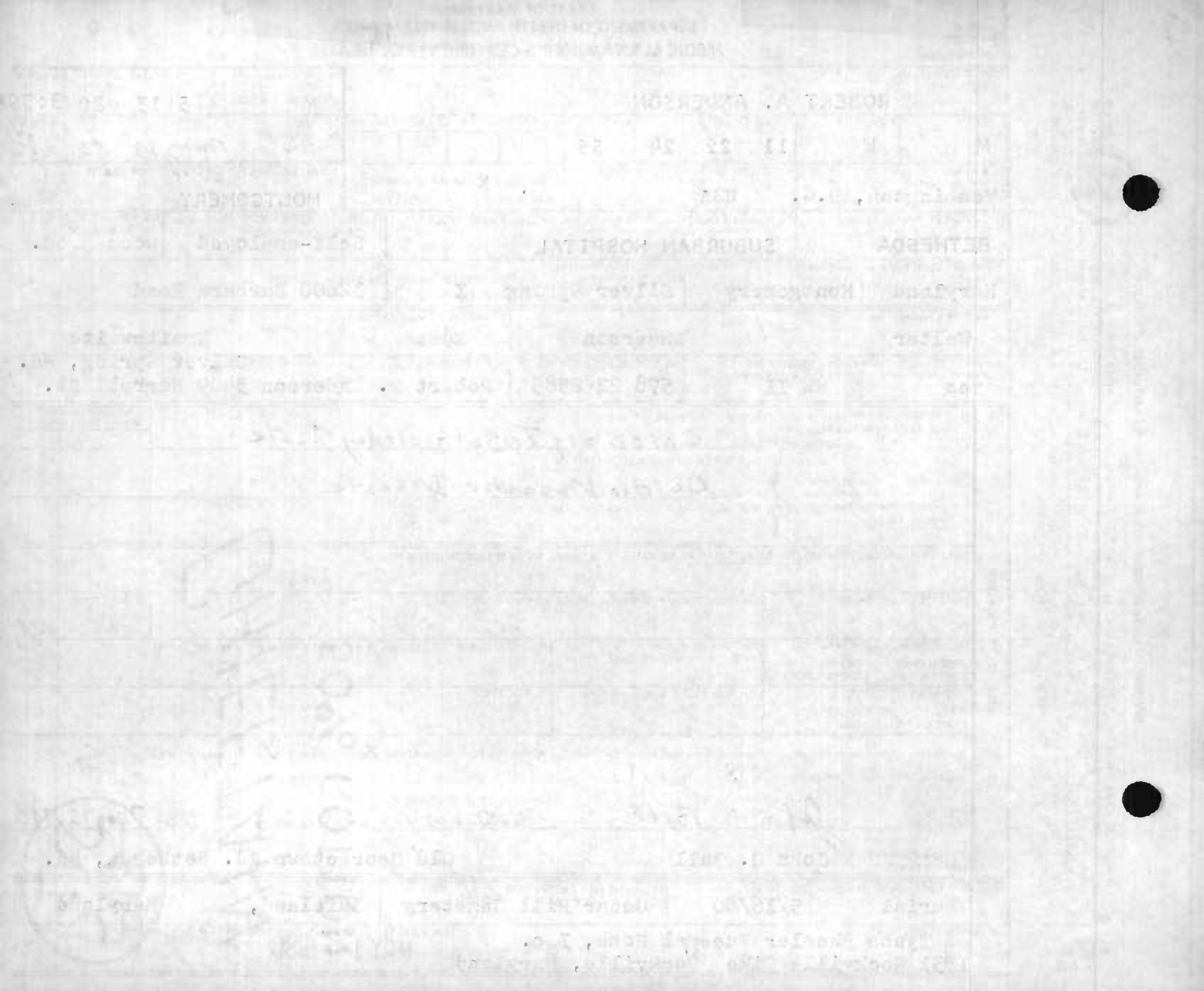
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Nathan J. ALEGAND</b>					2a. DATE OF DEATH MONTH <b>5</b> DAY <b>16</b> YEAR <b>80</b>				
3 SEX <b>MALE</b>					4 RACE <b>WHITE</b>				
5 DATE OF BIRTH MONTH <b>MAY</b> DAY <b>15</b> YEAR <b>1890</b>					6 AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>				
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holt Cross Hospital</b>				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>WALLPAPER</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>CONTRACTOR</b>				
13a. STATE <b>MARYLAND</b>					13b. CITY OR TOWN <b>SILVER SPRING</b>				
14. FATHER'S NAME FIRST <b>JOSEPH</b> MIDDLE <b>ALEGAND</b> LAST <b>ALEGAND</b>					15. MOTHER'S MAIDEN NAME FIRST <b>ESTHER</b> MIDDLE <b>KATZ</b> LAST <b>KATZ</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>YES</b>					16b. SOCIAL SECURITY NO. <b>577-46-2351</b>				
17 INFORMANT ADDRESS <b>IDA ALEGAND, same as #13</b>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Renal Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>46 hours</b> <b>17 yrs.</b> <b>Unknown</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>May 2</b> 19 <b>80</b> to <b>May 16</b> 19 <b>80</b> , that (I) (was) last saw the deceased alive on <b>May 16</b> 19 <b>80</b> and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Aaron H. Traum</b> DEGREE <b>MD</b>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>May 16 1980</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AARON H. TRAUM, MD.</b>					22e. ADDRESS <b>8915 GEORGIA AVENUE, SILVER SPRING, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>5/18/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GARDEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FALLS CHURCH VIRGINIA</b>		
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert H. Brady</b>		
232 CARROLL STREET, N. W., WASHINGTON, D. C.									





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13185					
1- STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT A. ANDERSON</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>5 13 1980</b>		2b. HOUR <b>3:30 PM</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>22</b> YEAR <b>24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD <b>May 13 1980</b>		2d. HOUR <b>3:39 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b>					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self-employed</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>wood prod.</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12600 Barbara Road</b>							
14. FATHER'S NAME FIRST <b>Walter</b> MIDDLE <b></b> LAST <b>Anderson</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Edna</b> MIDDLE <b></b> LAST <b>Braithwaite</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>578 22 2585</b>		17. INFORMANT <b>Robert M. Anderson</b>				ADDRESS <b>3409 Harrell St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Cardio Vascular Disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>May 13, 1980</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>				ADDRESS <b>Old Georgetown Rd. Bethesda, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/16/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Suitland,</b> COUNTY <b>Maryland</b> STATE <b></b>							
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> <b>1331 Rockville Pike Rockville, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 19 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Anderson</b>							





STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13186	
1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Leonard A. Accosi</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>May 22 1980</b>	
3. SEX <b>M</b> 4. RACE <b>W</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>June 30 1969</b> 6. AGE (IN YEARS) LAST BIRTHDAY <b>10 YRS.</b> 7c. DATE PRONOUNCED DEAD <b>May 22 1980</b>										2b. HOUR OF DEATH <b>12 P M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TILE SETTER</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>											
USUAL RESIDENCE (IF IN ALTERNATE HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b> 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 13e. STREET ADDRESS <b>9341 Columbia 131 Vd</b>											
14. FATHER'S NAME FIRST <b>ANDREA</b> MIDDLE <b>N.</b> LAST <b>ASCOSI</b> 15. MOTHER'S MAIDEN NAME FIRST <b>ANTONIA</b> MIDDLE <b>SILVESTRI</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WW II</b> 16b. SOCIAL SECURITY NO. <b>578-01-5060</b> 17. INFORMANT <b>JENNIE ASCOSI</b> ADDRESS <b>SAME AS 13</b> WIFE <b>WIFE</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4291</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>None</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b> TITLE (SPECIFY) <b>M.D. Dep</b> MEDICAL EXAMINER DATE SIGNED <b>May 22 1980</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b> ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b> 23b. DATE <b>5/24/80</b> 23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>											
24. FUNERAL DIRECTOR <b>FRANCIS J. COLLINS</b> NAME ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b> 25a. DATE REC'D. BY REGISTRAR <b>MAY 23 1980</b> 25b. REGISTRAR'S SIGNATURE <b>Histoyka Brady</b>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

NEW YORK

U.S.A.

THE STATE

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500 NEW BLVD. W. SILVER SPRING, MD. 20901

FRANCIS J. COLLIER

STATE OF MARYLAND

100001

TO HOSPITAL, WORK ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																											
1. FOR STATE REGISTRAR		8013187				REG. NO.																					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR											
Marie		Marie		H.-A.		Ashford		5-10-80		12		37				M											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MONTHS		11. DAYS		12. HOURS		13. MIN.							
Female		White		9-8-1900		79 YRS.						Montgomery								MD.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MONTHS		11. DAYS		12. HOURS		13. MIN.		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY									
Wash., D.C.		U.S.A.														Ret. Buyer Woodward & Lothrop											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Silver Spring		Holy Cross Hospital						Md.		Pr. Geo.		Avondale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4602 - Russell Ave.		J.		Marie							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		18. ADDRESS		19. SAME AS		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		20b. SOCIAL SECURITY NO		21. INFORMANT		22. ADDRESS							
J.		Marie		No		577-01-4270		A Cecilia Anglin (Sister)		Same as		above		No													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. PART 1. DEATH WAS CAUSED BY.		21. IMMEDIATE CAUSE (a)		22. DUE TO, OR AS A CONSEQUENCE OF		23. (b)		24. DUE TO, OR AS A CONSEQUENCE OF		25. (c)		26. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		27. age, chronic heart disease, severe peripheral vascular disease		28. 19a. DATE OF OPERATION		29. 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		30. 19c. AUTOPSY?		31. 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
496-				Cardiomyopathy				chronic obstructive lung disease + CAD																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE		21j. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21k. DATE OF OPERATION		21l. CONDITION FOR WHICH OPERATION WAS PERFORMED		21m. AUTOPSY?		21n. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
22a. I certify that (I) (this hospital) attended the deceased from 5/10/80, 19 0000, that (II) (we) last saw the deceased alive on 5/10/80, 19 0000, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DEGREE		22d. DATE SIGNED		22e. ATTENDING PHYSICIAN		22f. MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF <input type="checkbox"/>		22g. CITY OR TOWN		22h. COUNTY		22i. STATE		22j. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22k. DATE OF OPERATION		22l. CONDITION FOR WHICH OPERATION WAS PERFORMED		22m. AUTOPSY?		22n. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		Elliott R		MD		5/11/80																					
22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22b. ADDRESS		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION		22e. CITY OR TOWN		22f. COUNTY		22g. STATE		22h. DATE REC'D. BY REGISTRAR		22i. REGISTRAR'S SIGNATURE		22j. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22k. DATE OF OPERATION		22l. CONDITION FOR WHICH OPERATION WAS PERFORMED		22m. AUTOPSY?		22n. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
Elliot R		9410 OLD GEORGETOWN RD BETH AD		Mt. Olivet Cem.		Washington, D.C.								MAY 19 1980		Hofrey/Roby											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY		23g. STATE		23h. DATE REC'D. BY REGISTRAR		23i. REGISTRAR'S SIGNATURE		23j. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		23k. DATE OF OPERATION		23l. CONDITION FOR WHICH OPERATION WAS PERFORMED		23m. AUTOPSY?		23n. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
Burial		5-14-80		Mt. Olivet Cem.		Washington, D.C.								MAY 19 1980		Hofrey/Roby											
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE		24e. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		24f. DATE OF OPERATION		24g. CONDITION FOR WHICH OPERATION WAS PERFORMED		24h. AUTOPSY?		24i. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		24j. DATE OF OPERATION		24k. CONDITION FOR WHICH OPERATION WAS PERFORMED		24l. AUTOPSY?		24m. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
Nalley's F.H. Inc.		Mt. Rainier, Md.		MAY 19 1980		Hofrey/Roby																					

THE UNIVERSITY OF CHICAGO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 0 1 3 1 8 8		
1. FOR STATE REGISTRAR			REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <del>RYAN</del> <del>STANLEY</del> <del>HELEN</del>			2a. DATE OF DEATH MONTH DAY YEAR MAY 28 1980		2b. HOUR 2:30 P.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 19, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 11506 CHARLTON DRIVE	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN DEREVANYCK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA DUDICH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 155-12-3529A		17. INFORMANT DAUGHTER MARION MCCARTHY		ADDRESS 11506 CHARLTON DR. SILVER SPRING MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u> <u>heart disease and</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u> 4 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/28/80</u> to <u>5/28/80</u> , that (I) (we) last saw the deceased alive on <u>5/28/80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Barry N. Rosenbaum, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/28/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY N. ROSENBAUM			22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20795				
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) BURIAL		23b. DATE 5/30/80		23c. NAME OF CEMETERY OR CREMATORY BAVVIEW CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE JERSEY CITY HUDSON N.J.	
24. FUNERAL DIRECTOR FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR MAY 29 1980		25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>	

500 W. 11th Blvd. N. Silver Spring, Md. 20901  
 FRANCIS J. COLLINS  
 5/30/80  
 BARNETT CHRISTIAN  
 JEREMY CITY  
 HUNTON  
 MAY 8 1980

NO. 155-12-35294  
 MARION M. GARDIN  
 DAUGHTER  
 WHITE  
 11504 CHARLTON DR.  
 SILVER SPRING, MD.  
 JOHN

HARVARD  
 11504 CHARLTON DRIVE  
 WOMENAKER

AUSTRIA  
 WHITE  
 87

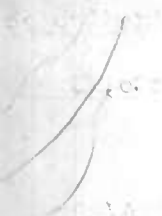
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13189	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Roy Frank Bartlett, JR</b>						2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5 3 19 80</b>		2b. HOUR M <b>AM</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5/15/54</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>25 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>5 3 19 80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK) <b>Apprentice Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5210 Saratoga Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Roy Frank Bartlett, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gayle Dabel</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-58-8613</b>		17. INFORMANT ADDRESS <b>Roy Frank Bartlett, Sr., same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7:15PM 5/3/ 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver of auto in collision with fixed object</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>roadway</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>WestBound 270/Falls Rd, Rockville, MontCo, MD</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Hormez R. Guard, M.D.</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>5/4/80</b>			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS <b>111 Penn Street, Balto., MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>5/7/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 9 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>			
7557 Wisconsin Avenue, Bethesda, MD											

DE:



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

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1- FOR  
STATE  
REGISTRAR

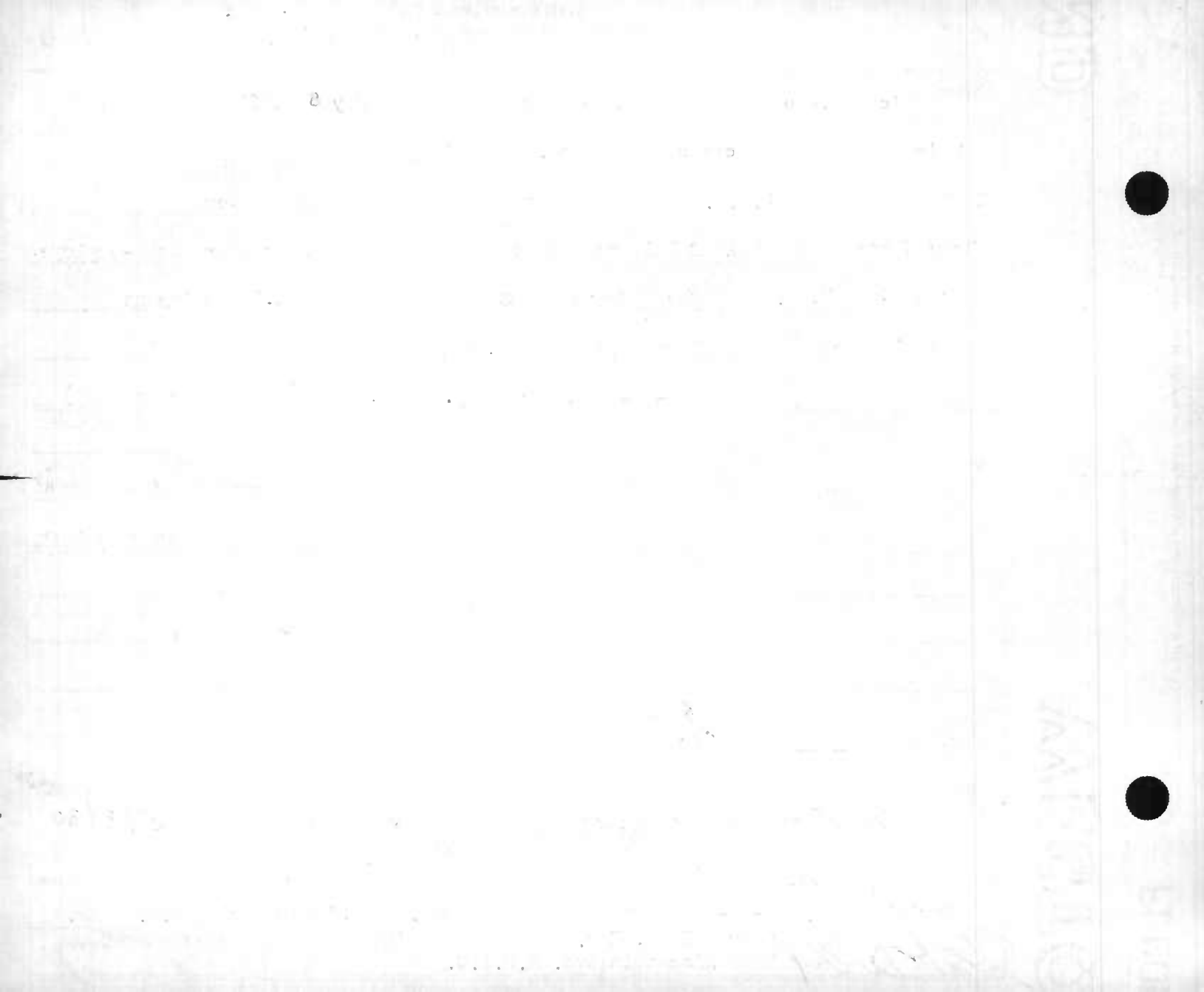
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Nicolangelo Bartolomeo</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 8, 1980</b>			2b. HOUR <b>6:15 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 12 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>91</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN. <b>91</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5315 Baltimore Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tool Sharpener</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5315 Baltimore Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Domenicangelo Bartolomeo</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Buttino</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-30-1070A</b>		17. INFORMANT ADDRESS <b>John A. Bartolomeo (son) same as (13)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Stroke</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>One week</b> <b>One year</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>April 11</b> , 19 <b>77</b> , to <b>May</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>May 5</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Christopher Unger</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>5/8/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Christopher Unger, M.D.</b>				22e. ADDRESS <b>8218 Wisconsin Ave. Bethesda, Md. 20014</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-12-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring P.G. Md.</b>			
24. FUNERAL DIRECTOR Name <b>DeVol Funeral Home Inc.</b> Address <b>2222 Wisconsin Ave. N.W.D.C.</b>				25a. DATE RECEIVED BY REGISTRAR <b>MAY 14 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Christy A. Brady</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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1- FOR  
STATE  
REGISTRAR

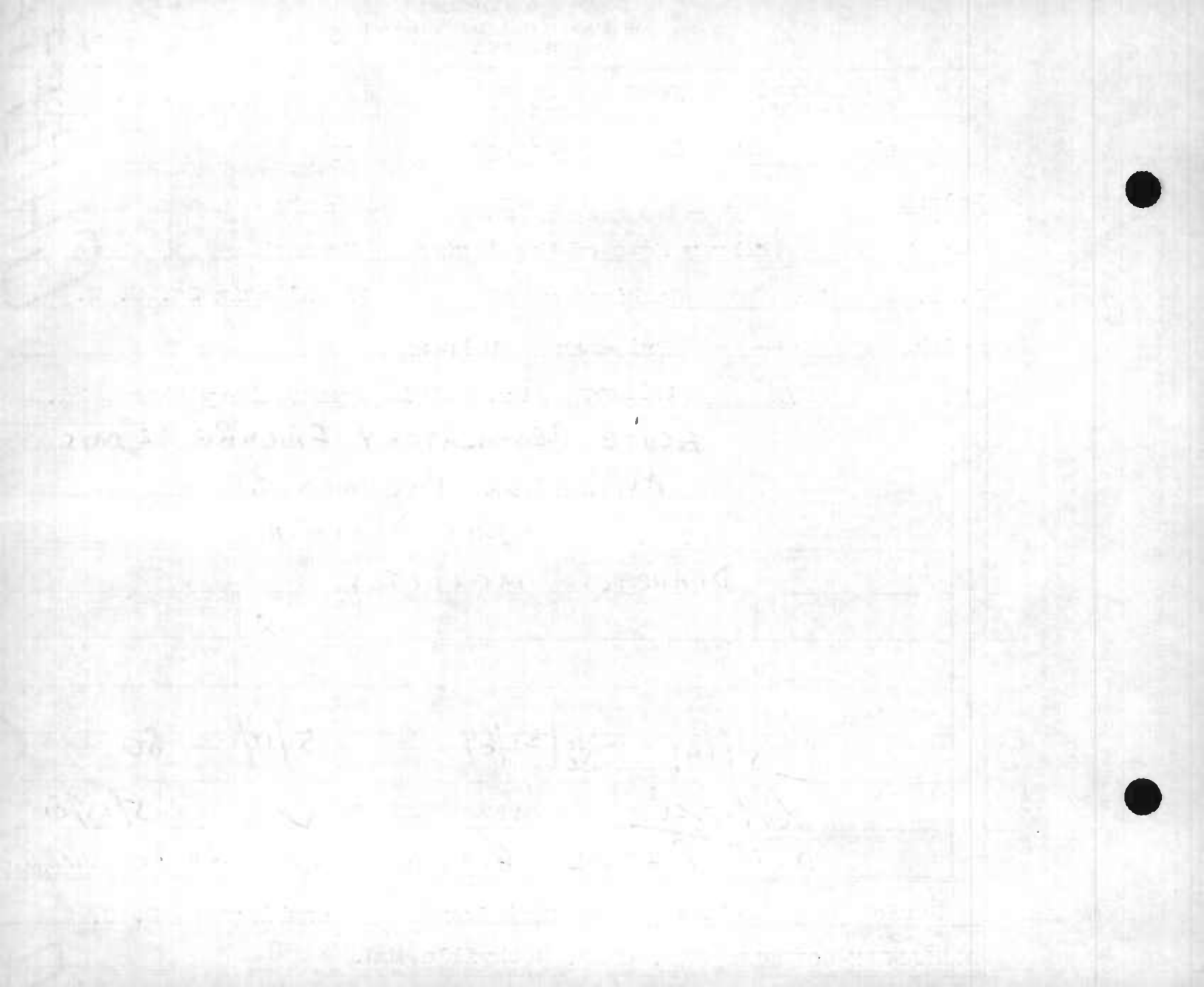
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Jennie</u> MIDDLE <u>Myers</u> LAST <u>Bass</u> <i>Jennie Myers Bass</i>		2a. DATE OF DEATH MONTH <u>May</u> DAY <u>14</u> YEAR <u>80</u>		2b. HOUR <u>10:10</u> M.	
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH <u>12</u> DAY <u>18</u> YEAR <u>84</u>	
6. AGE (IN YEARS LAST BIRTHDAY) <u>95</u> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Poland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Hebrew Home of Washington</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		13a. STREET ADDRESS <u>29 Gallatin St. N. W.</u>			
13b. CITY OR TOWN <u>D. C.</u>		13c. COUNTY <u>None</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <u>Moishe</u> MIDDLE <u>---</u> LAST <u>Friedman</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Unknown</u> MIDDLE <u>---</u> LAST <u>---</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>N/A</u>		17. INFORMANT ADDRESS <u>Dr. Melvin Myers, Chevy Chase, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RESPIRATORY FAILURE</u> 5070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASPIRATION PNEUMONITIS</u> (c) <u>SENILE DEMENTIA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>DIABETES MELLITUS</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR <u>A.M.</u> MONTH <u>19</u> DAY <u>19</u> YEAR <u>80</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <u>---</u> CITY OR TOWN <u>---</u> COUNTY <u>---</u> STATE <u>---</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/21/69</u> , 19 <u>80</u> , to <u>5/14/80</u> , that (I) (we) last saw the deceased alive on <u>5/14/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>D.D. Patel</u>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/15/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D. D. PATEL</u>		22e. ADDRESS <u>6121 MONTROSE RD. ROCKVILLE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>5-16-80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tifereth Israel</u>	
23d. LOCATION CITY OR TOWN <u>Washington</u> COUNTY <u>D. C.</u> STATE <u>---</u>		24. FUNERAL DIRECTOR NAME <u>DANZANSKY-GOLDBERG MEM. CHAP. Rockville, MD.</u> ADDRESS <u>---</u>			
25a. DATE REC'D. BY REGISTRAR <u>MAY 28 1980</u>		25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	3	1	9	2
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Jeanette			BATEHAM						May			1	1980	5:30 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		8. UNDER 24 HRS		
Female			Caucasian			Feb. 2 1938			42			YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Florida			USA						Montgomery			MD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda			National Naval Medical Center			Registered Nurse			Medicine							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Florida			Hillsborough			Tampa			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14006 Briardale Lane				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST			FIRST MIDDLE LAST													
William A. Bowen			Byrd Nell (not known)													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			267 60 2135			Charles Bateham			12 Palm Drive, Key West, FL							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) Cerebral edema																
1919 DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
(b) Glioblastoma																
DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
			HOUR A.M. MONTH DAY YEAR													
			P.M. 19													
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION										
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from April 3 1980 to May 1 1980, that (I) (we) last saw the deceased on May 1 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE										DEGREE			22c. DATE SIGNED			
													2 May 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS						
L. H. FINK, M.D.										National Naval Medical Center, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION							
Burial			May 5, 1980			Arlington National			Arlington			COUNTY		STATE		
24. FUNERAL DIRECTOR										25a. BY REQUEST OF			25b. REGISTERED			
NAME ADDRESS										NAME ADDRESS						
W. W. Chambers Co.										Silver Spring, Md.						

10-1-5

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

DATE 10-1-5

BY 10-1-5

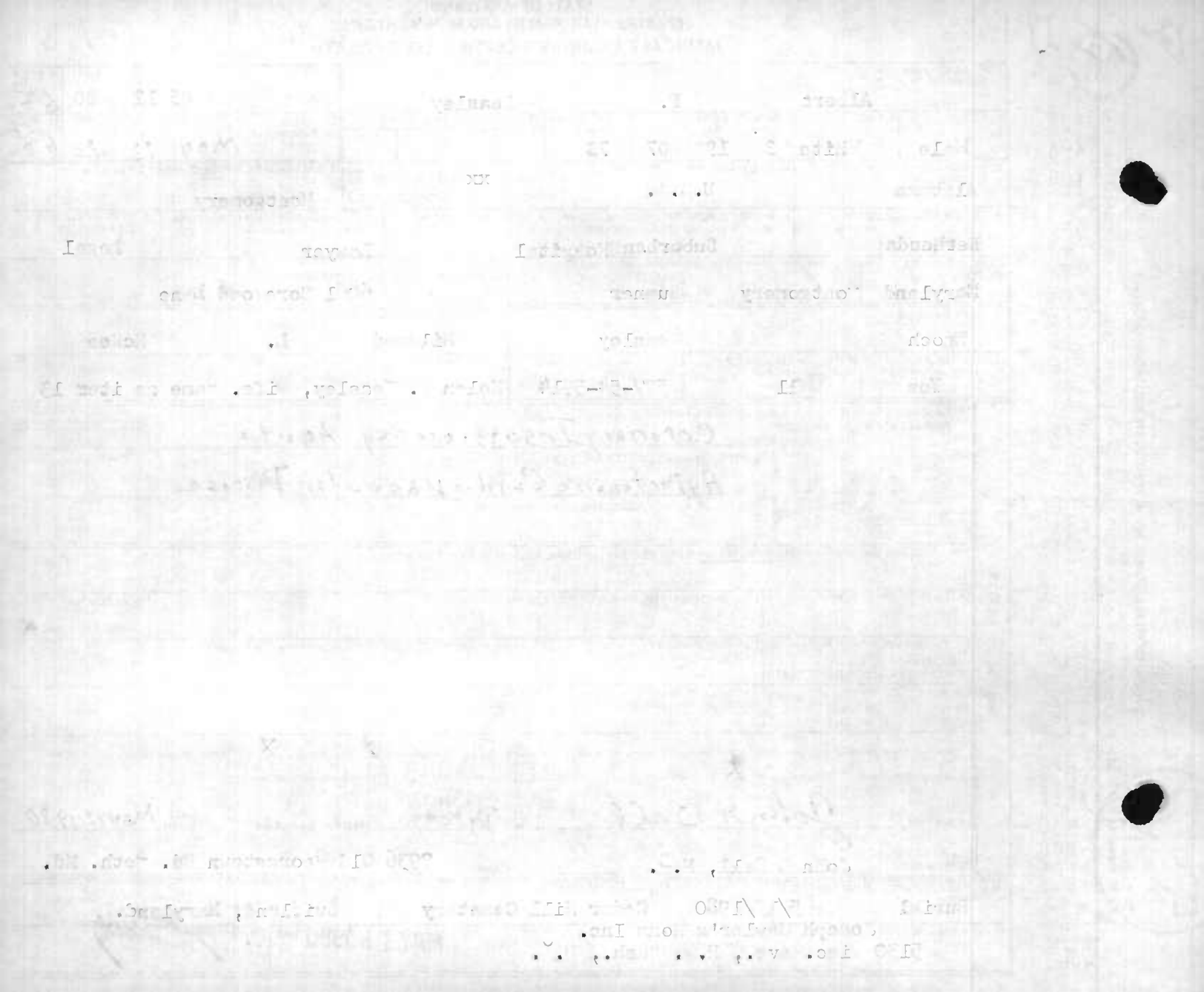
(original text)

2000

10-1-5

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 13193			
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH		2b. HOUR	
Albert F. Beasley																				MONTH DAY YEAR		6:52 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR							
Male		White		3 19 07		73 YRS.		MONTHS DAYS HOURS MIN.				May 12 1980		6:52 P.M.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD							
Alabama				U.S.A.								Montgomery											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda				Suburban Hospital				Lawyer				Legal											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
Maryland		Montgomery		Summer		YES <input type="checkbox"/> NO <input type="checkbox"/>		6001 Corewood Lane															
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																		
FIRST MIDDLE LAST					FIRST MIDDLE LAST																		
Enoch Beasley					Mildred L. McKee																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS								
Yes					WWII					577-54-5914					Helen F. Beasley, Wife. Same as item 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART I DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
(b) <u>Hypertensive Cardiovascular Disease.</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?								
															YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
					HOUR A.M. MONTH DAY YEAR																		
					P.M. 19																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION													
										STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE					TITLE (SPECIFY)					DATE SIGNED													
John G. Ball					M.D. Deputy					May 12, 1980													
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS																		
John G. Ball, M.D.					7936 Old Georgetown Rd. Beth. Md.																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION								
Burial					5/15/1980					Cedar Hill Cemetery					Suitland, Maryland								
24. FUNERAL DIRECTOR																							
NAME ADDRESS																							
Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.																							
25. DATE REC'D BY REGISTRAR																							
MAY 16 1980																							
REGISTRAR'S SIGNATURE																							



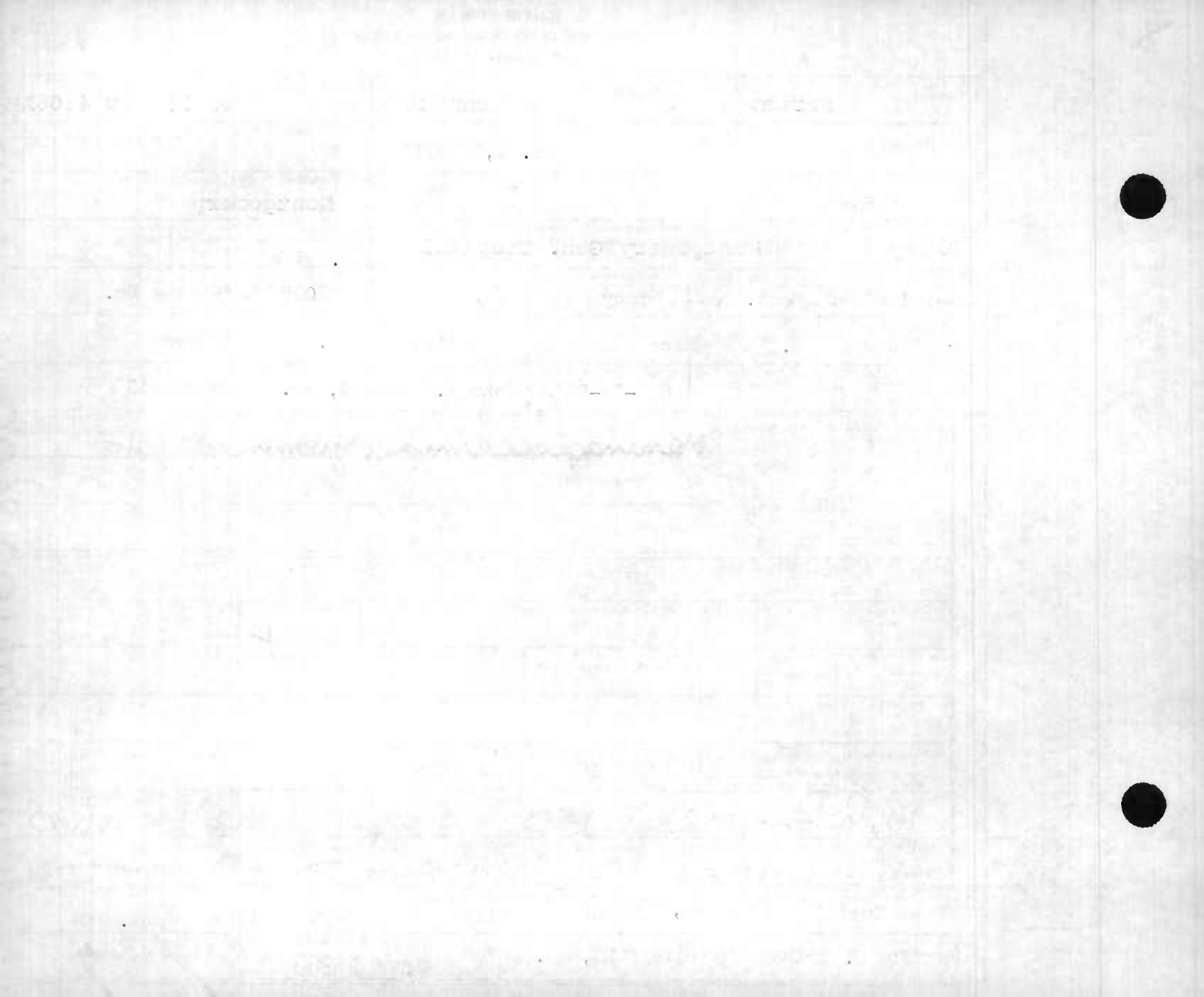
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 80 13194							
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Martha Chase Bennett			2a DATE OF DEATH MONTH DAY YEAR 05 19 80		2b HOUR 4:06AM		
3 SEX Female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Dec. 8, 1937		6 AGE (IN YEARS LAST BIRTHDAY) 42		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. wife		12b KIND OF BUSINESS OR INDUSTRY Home		
13a STATE Maryland			13b COUNTY Mont.		13c CITY OR TOWN Olney		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 18025 Lafayette Dr.	
14 FATHER'S NAME FIRST MIDDLE LAST Hayden W. Chase					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Murfel W. Belyea					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 006-34-9646		17 INFORMANT ADDRESS John T. Bennett, Jr. Same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Meningococcemia, fulminant</u> <u>1362</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/15	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>5/18</u> 19 <u>80</u> to <u>5/19</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>5/19</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b SIGNATURE <u>[Signature]</u> MD					DEGREE MD			22c. DATE SIGNED 5/19/80		
22e PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. LODMELL, MD.					22e ADDRESS 18111 PRINCE PHILIP DR. OLNEY MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE May 22, 1980		23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville Mont. Md.			
24 FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20760					25a. DATE REC'D. BY REGISTRAR MAY 22 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAM - 17  
(VR A13 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
Ethel E. Berry								May 7 1980								1030 AM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE IN YEARS		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female	Caucasian	Feb. 1. 03		77 YRS.						May 7 1980								1030 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Illinois		U.S.A.		WIDOWED		DIVORCED		Montgomery											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Olex		Montgomery Gen'l. Hosp.		Homemaker		Home													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Minnesota		Not available		Apple Valley		NO		8701 Upper 129th Court											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Frank		Mary																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT															
No		323 07 7970		John A. Berry		Rockville, Md.													

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

4291  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) Cerebral Vascular Accident

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

None

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S NAME (TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS

2919 Seminary Road Silver Spring  
Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

5/14/80

23c. NAME OF CEMETERY OR CREMATORY

All Saints Cemetery

23d. LOCATION CITY OR TOWN

Des Plaines, Illinois

24. FUNERAL DIRECTOR NAME

ROBERT A. RUMPHREY FUNERAL  
HOMES, P.A., ROCKVILLE, MARYLAND

25a. DATE RECD BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

MAY 12 1980  
[Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. FOR STATE REGISTRAR			REG. NO. 8 0 1 3 1 9 6														
1 DECEASED NAME (TYPE OR PRINT)			FIRST MARY			MIDDLE -			LAST BIRO			2a. DATE OF DEATH MONTH DAY YEAR MAY 10, 1980			2b. HOUR 7:50 PM		
3 SEX Female			4 RACE White			5 DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1894			6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.			7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS. HOURS MIN.			
7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HUNGARY			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.								
10 CITY OR TOWN OF DEATH Silver Spring,			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Silver Home- 2112 Parker Ave., Spring, Md.			12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife-retired			12b. KIND OF BUSINESS OR INDUSTRY								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13r. STREET ADDRESS Silver 2112 Parker Avenue, Spring, Md. 20902		
14 FATHER'S NAME FIRST ANDREW MIDDLE - LAST KEREKES			15 MOTHER'S MAIDEN NAME FIRST MARIA KEREKES MIDDLE - LAST (maiden name-unknown)														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578-50-3784			17 INFORMANT Daughter- Mary (Biro) Ebner-2112 Parker Ave., Spring, Md.			ADDRESS Silver								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 193- cardiac arrest																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) anemia															6 mos		
DUE TO, OR AS A CONSEQUENCE OF (c) carcinoma of the thyroid + malnutrition															7 yes		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabete Mellitor																	
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (i) (this hospital) attended the deceased from 5-9-80 to 5-10-80, that (ii) (we) lost saw the deceased alive on 5-10-80, and that in my (iii) (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) did (did not) view the body after death.																	
22b. SIGNATURE Richard M. Auld			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5-11-80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD M. AULD			22e. ADDRESS 80a Views Mill Rd. Rockville, Md 20851														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/13/80			23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL			23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA								
24 FUNERAL DIRECTOR FRANCIS J. COLLINS			25a. DATE REC'D. BY REGISTRAR MAY 15 1980			25b. REGISTRAR'S SIGNATURE [Signature]											
500 UNIVERSITY BLVD., W., SILVER SPRING, MD. 20901																	



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8013197

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gertrude Levenia Bladen			2a. DATE OF DEATH MONTH DAY YEAR 5-1-80			2b. HOUR 12:10 PM				
3 SEX Female		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR 9 16 95		6 AGE (IN YEARS LAST BIRTHDAY) 84				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Virginia			13b. COUNTY Stafford		13c. CITY OR TOWN Fredericksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Julius H. Curtis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Dandridge							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 224-92-0551		17 INFORMANT daughter Zellah M. Brown				ADDRESS 9002 Flower Ave. Silver Spring, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 31, 1980, to May 1, 1980, that (he)(we) lost saw the deceased alive on May 1, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Bernard A. Fitzgerald MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/1/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD					22e. ADDRESS 217 University Blvd E, Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 3, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins					25a. DATE REC'D. BY REGISTRAR MAY 5 1980		25b. SIGNATURE [Signature]			
500 University Blvd., W. Silver Spring, Md.										

BP

200 University Ave., Silver Spring, Md.  
 Francis J. Collins  
 Jan. 3, 1980 Cedar Hill, Conn.

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 FOR  
 1- STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST John		MIDDLE WILLARD		LAST BLADES		20. DATE KNOWN OF ESTI- DEATH MATED		MONTH 12		DAY 26		YEAR 1980		24 HOUR 6:40 PM	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 12	DAY 26	YEAR 1980	6. AGE (IN YEARS) LAST BIRTHDAY 87 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	21. DATE PRONOUNCED DEAD		MONTH 12		DAY 26		YEAR 1980		24 HOUR 6:40 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COMMERCIAL ARTIST		12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Florida		13b. COUNTY SARASOTA		13c. CITY OR TOWN Nokomai		13d. INSIDE CITY LIMITS? YES NO		13e. STREET ADDRESS 24 Long Ben Lane									
14. FATHER'S NAME FIRST JOHN		MIDDLE WILLARD		LAST BLADES		15. MOTHER'S MAIDEN NAME FIRST GERTRUDE		MIDDLE RUSSELL		LAST RUSSELL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 011-07-2069		17. INFORMANT DAUGHTER SUSAN BLADES		ADDRESS 2406 DEXTER AVE SILVER SPRING, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Chronic Obstructive Pulmonary Disease</u>																	
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES NO													
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER 1919 SEMINARY ROAD, SILVER SPRING, MD.		DATE SIGNED May 22 1980											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/23/80		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN ALEXANDRIA		COUNTY VIRGINIA		STATE							
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR MAY 23 1980		25b. REGISTRAR'S SIGNATURE [Signature]													
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																	

BP

 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



200 MAIN ROAD, N. SILVER SPRING, MD. 20901  
FRANCIS J. COLLINS  
COMMUNICATION

5452/10 METROPOLITAN CEMETERY ALEXANDRIA VIRGINIA

JOHN S. ROBERTS

1919 CENTINARA ROAD, SILVER SPRING, MD.

NO

011-07-0049

SUSAN BLAIR

SILVER SPRING, MD.

JOHN

STARK

BLAIR

CENTINARA

ROBERTS

ATLANTA

COMMERCIAL ARTIST

WASHINGTON, D.C.

STILL  
LIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EUSTACE BOGNER</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>5-25-80</b>		2b. HOUR MIN <b>9:15 A M</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8-2-1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. <b>86</b>		7 IF UNDER 1 YEAR MONTHS DAYS <b>9</b>		7 IF UNDER 24 HRS. HOURS MIN. <b>15</b>			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>							
10 CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSP</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BAKER</b>		12b KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a STATE <b>MARYLAND</b>		13b COUNTY <b>MONTGOMERY</b>		13c CITY OR TOWN <b>TAKOMA PARK</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>7714 CARROLL AVENUE</b>					
14 FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>578-01-8002</b>		17. INFORMANT <b>FRIEND</b>		ADDRESS <b>9 MARIGOLD CT. SILVER SPRING, MD.</b>							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>0381</b> IMMEDIATE CAUSE (a) <b>Septicemia - Staph aureus</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from <b>5/21/80</b> 19 <b>80</b> , to <b>5/25/80</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>5/25/80</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>David Cromwell MD</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/26/80</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID CROMWELL</b>						22e. ADDRESS <b>SILVER SPRING, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/28/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD PRI GEO MD.</b>							
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>						ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 29 1980</b>					

History of the body

DETENTION

D.O.A.

NY

BAKER

3416 CANNON AVE

XX

TATUM PARK

WINGGOMERY

WINGGOMERY

UNKNOWN

UNKNOWN

9 WATGOLD CT  
SILVER SPRING MD

STREET

HELMUTH T. BACHMAN

274-01-2002

NY

WATGOLD

SILVER SPRING

CEMENTELL

DAVID

9 WATGOLD CT

SILVER SPRING

274-01-2002

DETENTION

500 UNIVERSITY BLVD, SILVER SPRING, MARYLAND 20910  
FRANCIS J. COLLIER  
274-01-2002

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 2 0 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Marie Hewitt Bohrer</u>				2a. DATE OF DEATH MONTH <u>5</u> DAY <u>7</u> YEAR <u>80</u>		2b. HOUR <u>11:50 A</u>	
3 SEX <u>Female</u>		4 RACE <u>White</u>		5 DATE OF BIRTH MONTH <u>3</u> DAY <u>17</u> YEAR <u>95</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>85</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.	
10 CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Our Dearban Hosp</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Mont</u>				13c. CITY OR TOWN <u>Kensington</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST <u>AARON</u> MIDDLE <u>HEWITT</u> LAST <u>HEWITT</u>				15. MOTHER'S MAIDEN NAME FIRST <u>MARY</u> MIDDLE <u>ELIZABETH</u> LAST <u>BROUGHS</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>213-54-6911</u>		17. INFORMANT ADDRESS <u>MARIE B. PATTERSON SAME AS 13 DAUGHTER</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BACTERIAL SEPSIS</u> <u>436-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MAJOR CEREBRO-VASCULAR ACCIDENT</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHOLECYSTITIS, S/P CHOLECYSTECTOMY + COMMONDUCT EXPL</u>							
19a. DATE OF OPERATION <u>4/3/80</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CHOLECYSTITIS/CHOLEDOCHOLITHIASIS</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/26</u> , 19 <u>80</u> , to <u>5/7</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>5/7</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Ernest D. Hanowell</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>5/7/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ERNEST D. HANOWELL, MD</u>				22e. ADDRESS <u>10401 OLD GTOWN RD BETHESDA MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>5/10/80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEMETERY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>ROCKVILLE MONT MD.</u>	
24. FUNERAL DIRECTOR <u>FRANCIS J. COLLINS</u> NAME ADDRESS <u>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 9 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

280 UNIV. BLVD., N. SILVER SPRING, MD. 20901  
FRANCIS J. COLLIER  
F/10/60 ST. MARY'S CEMETERY ROCKVILLE MD.

2/5/60  
MD.

1/3/60  
CHURCH OF THE HOLY TRINITY - SILVER SPRING, MD.

ALISON L. COLLIER - MARY'S CEMETERY, ROCKVILLE, MD.

BAPTIST CHURCH

NO 218-24-6911 MARIE B. PATTERSON DUE AS 12 DAUGHTER  
AARON HENRY MARY ELIZABETH BROOKS

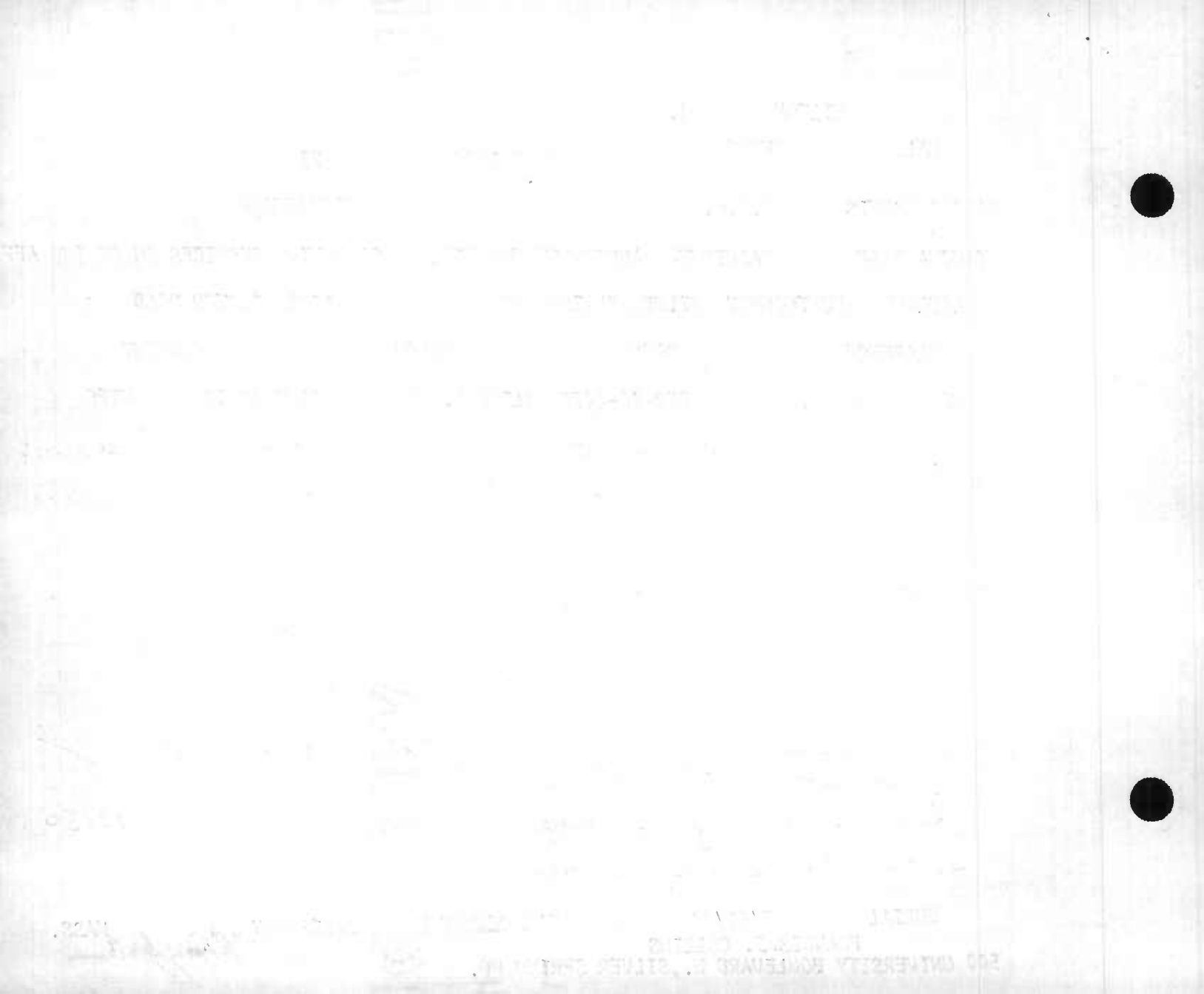
U.S.A. HONORABLE

1/20/60

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		5 23 80		9:06A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		NOV 27, 1906		73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
MASSACHUSETTS		U.S.A.				MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TAKOMA PARK		WASHINGTON ADVENTIST HOSPITAL		ACCOUNTING SERVICES BU OF IND AFF.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		579-40-4450	
CLARENCE		BOYD		17 INFORMANT		ADDRESS	
				ALICE M. BOYD		SAME AS 13 WIFE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410 -				Acute Myocardial Infarction		6 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b) Coronary Artery Disease		10 years	
				(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
Renal Insufficiency							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 73 to 5/23 19 80, that (I) (we) lost saw the deceased alive on 5/27 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING MEDICAL STAFF		22c. DATE SIGNED	
Keith M. Lindgren MD		PHYSICIAN		DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		5/23/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Keith M. Lindgren MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		5/27/80		LONG HILL CEMETERY		CITY OR TOWN COUNTY STATE	
						SALISBURY MASS.	
24 FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME FRANCIS J. COLLINS		MAY 29 1980		[Signature]			
500 UNIVERSITY BOULEVARD W., SILVER SPRING, MD.							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1 - STATE REGISTRAR					7 0 1 3 2 0 2					
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH					
RICHARD M. BRAY					05-18-80					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		2b HOUR		
MALE		W		June 12, 1915		64		3 30 PM		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Colorado		USA				MONTGOMERY		MD.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring		Holy Cross Hospital				Ret.-Dean American University				
13a STATE					13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Md.					Montgomery		Takoma Pk.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Edgar William Bray					Mattie Kate Ensign					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT			
No					None		220-34-2778 Jean J. Bray-wife 7051 Carroll Ave			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Congestive heart failure										
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease & myocardial infarction										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
Chronic obstructive lung disease; benign prostatic hypertrophy										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
5-8-80		Benign prostatic hypertrophy				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR								
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET		CITY OR TOWN COUNTY STATE				
22a I certify that (I) (we) attended the deceased from April 19 78, to 5-18-80, that (I) (we) last saw the deceased alive on 5-18-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED				
JASON GEIGER, M.D.						5-19-80				
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f DATE REC'D. BY REGISTRAR						
JASON GEIGER, M.D.		8830 CAMERON ST. SILVER SPRING MD. 20910		MAY 21 1980						
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		23e COUNTY		
Cremation		5-19-80		Lee's Crematory		Washington, D.C.		STATE		
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Lee Funeral Home		300-4th St. N.E. Wash.D.C.		20002		MAY 21 1980				

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Ученый журнал

• **THE END**

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State of New York

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None

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Page 1. 10-10-10

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28-21-2

● January 1, 1991

.., not in the

See General Note 300-14th St. S. 10th St. S.

CHIEF OF POLICE

5005

TO HOSPITAL/ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

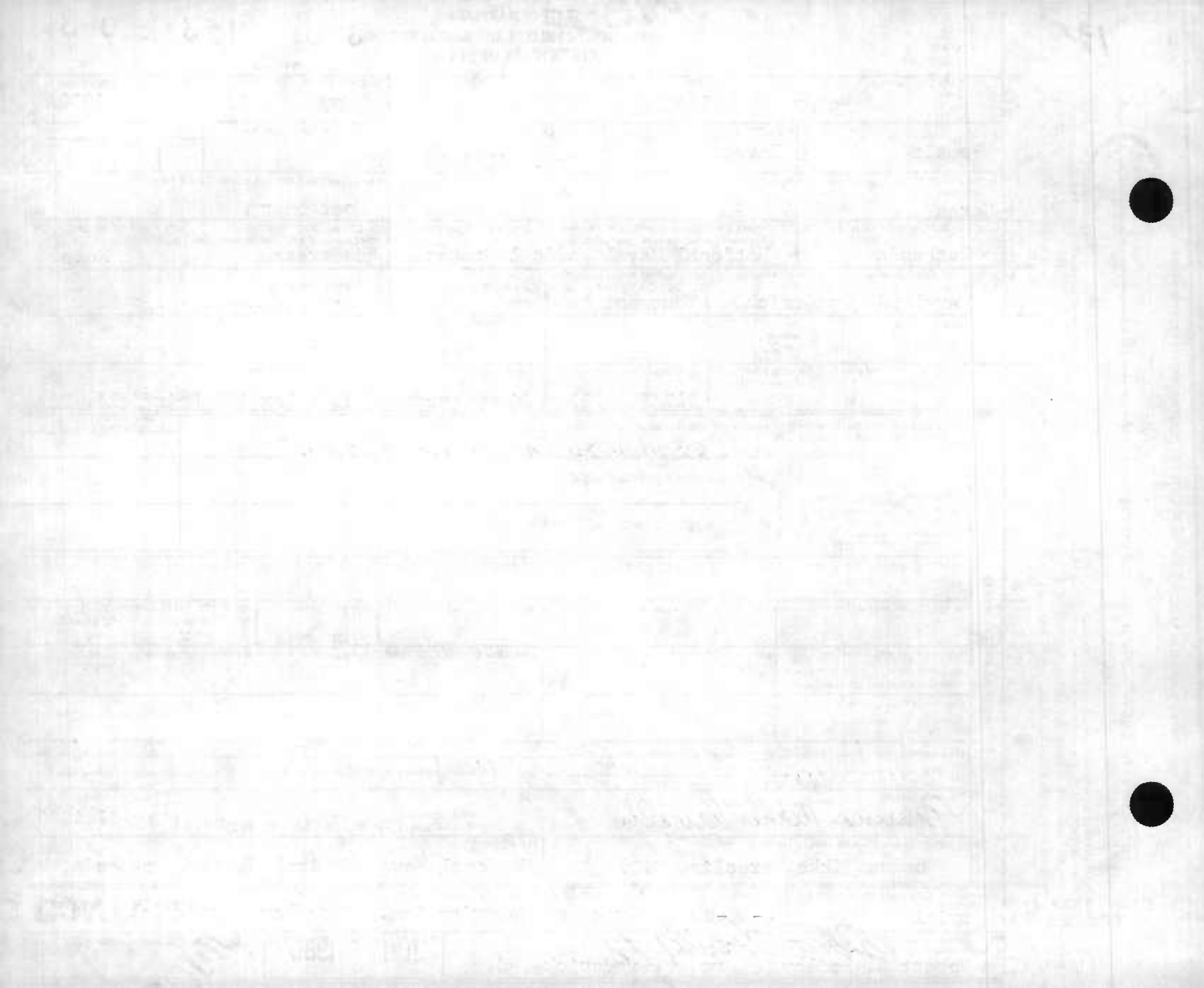
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Peggy Lee BRENNAN					2a. DATE OF DEATH MONTH DAY YEAR May 26 1980			2b. HOUR 1030A M	
3 SEX Female		4 RACE Korean		5 DATE OF BIRTH MONTH DAY YEAR Jan, 17 1930		6 AGE (IN YEARS LAST BIRTHDAY) 50 YRS		7 IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Maryland Frederick Thurmont					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 8201 RockyrIDGE Road		
14 FATHER'S NAME FIRST MIDDLE LAST Bok Dong Lee					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tae II CHOI				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 50 8733		17 INFORMANT ADDRESS Jimmy Brennan Rt. 1 Box 190 Fairfield, PA					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>DESSIMINATED Carcinoma of Breast</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I (this hospital) attended the deceased from May 5, 1980, to May 26, 1980, that (I/(we) last saw the deceased alive on May 26, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/(we) did) (did not) view the body after death.									
22b SIGNATURE Marina Nikke Vernalis				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED May 27, 1980			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Marina Nikke Vernalis, M.D.				22e ADDRESS National Naval Medical Center, Bethesda, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5-30-80		23c NAME OF CEMETERY OR CREMATORY Graceham Moravian Cem.		23d LOCATION CITY OR TOWN COUNTY STATE GracEham Frederick Md.			
24 FUNERAL DIRECTOR NAME Robert E. Dailey & Sons				Frederick, Md.		25a DATE REC'D. BY REGISTRAR JUN 2 1980		25b REGISTRAR'S SIGNATURE	

BP



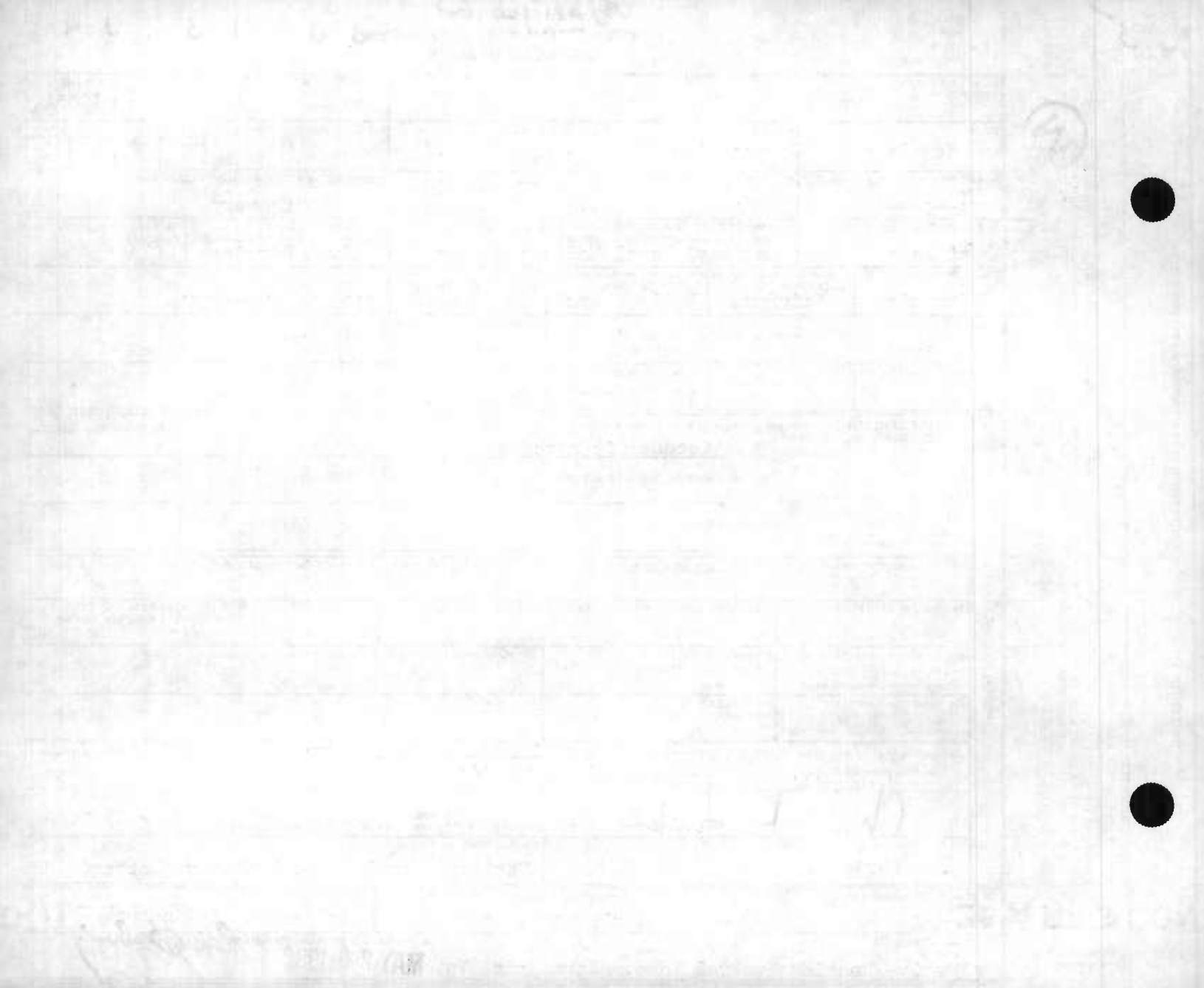
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 3 2 0 4			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Evelyn N. BRISCOE</b>				2a DATE OF DEATH MONTH DAY YEAR <b>May 15 1980</b>		2b HOUR <b>1005A</b> M	
3 SEX <b>female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 29 1910</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Civil Service</b>		12b KIND OF BUSINESS OR INDUSTRY <b>CIA</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a STATE <b>Virginia</b>		13b COUNTY <b>Fairfax</b>		13c CITY OR TOWN <b>Falls Church</b>		13e STREET ADDRESS <b>6129 Leesburg Pike</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Fred Koch</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn Lloyd</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>578 24 5307</b>		17 INFORMANT <b>Joseph E. Briscoe</b>		ADDRESS <b>See item 13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Osteogenic sarcoma</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (I/ (this hospital) attended the deceased from <b>Apr. 16</b> 19 <b>80</b> , to <b>May 15</b> 19 <b>80</b> , that (I/ (we) last saw the deceased alive on <b>May 15</b> 19 <b>80</b> , and that in (my/ (our) opinion death occurred on the date and hour and from the causes stated above, (I/ (we) did/ (did not) view the body after death.							
22b SIGNATURE <b>Chris K. Fenton</b> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED <b>May 15, 1980</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Chris K. Fenton, M.D.</b>				22e ADDRESS <b>National Naval Medical Center, Bethesda, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>5-20-80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Arlington Va.</b>	
24 FUNERAL DIRECTOR NAME <b>Everly-Wheatley Funeral Home, Alexandria, Va.</b> ADDRESS				25a DATE REC'D. BY REGISTRAR <b>MAY 26 1980</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										70		13205	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR					
Marian Lorraine Brogan				5 20 80				330 P.M.					
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		white		9 27 56		53 YRS		MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania		USA				Montgomery MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Rockville		Shady Grove Adventist Hosp.		housewife		home							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
md				Montgomery		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1611 Sweet ST					
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME									
John L. McGarry				Genevieve Warg									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS							
no				209 20 7662		John W. Brogan same as 13c							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) hepatic encephalopathy										1 mo.			
303- DUE TO, OR AS A CONSEQUENCE OF (b) gastro intestinal bleed										hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) alcoholism										yrs.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
fractured pelvis, humerus													
18a. DATE OF OPERATION		18b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/3 1980, to 5/20 1980, that (I) (we) lost saw the deceased alive on 5/20 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
John R. Melnick MD				MD				5/20/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
John R. Melnick MD				16220 Frederick Rd, Gaithersburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		5/24/80		St. Mary's Cemetery		Rockville,		Maryland					
24 FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
1331 Tyson Wheeler Funeral Home, Inc. Rockville, Maryland						MAY 26 1980		Rickey Halbrudy					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					70 0 1 3 2 0 6				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Elmer Clinton Brown, Sr.					5/5/80				
3. SEX					2b. HOUR				
male					2.14 P.M.				
4. RACE					5. DATE OF BIRTH				
White					Nov 23 1910				
6. AGE (IN YEARS LAST BIRTHDAY)					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				
69					WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington DC					Montgomery County MD				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				
Silver Spring					Holy Cross Hospital				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
Co. Repair					Telephone Co				
13a. STATE					13b. COUNTY				
Maryland					St. Mary's Hollywood				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Robert Brown					Margaretta Keller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
No					577 01 0844				
17. INFORMANT					ADDRESS				
Mary Evelyn Brown					Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Metastatic Carcinoma									
1629 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Lung									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
Jan, 1980									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
Carcinoma Left Lung									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 4/22 19 80 to 5/5 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so, the deceased alive on 4/22 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.)									
22b. SIGNATURE									
22c. DATE SIGNED									
5/6/80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
DARRY J. LEVIN									
22e. ADDRESS									
1234-19th St NW WASH DC									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
Burial									
23b. DATE									
8 May 1980									
23c. NAME OF CEMETERY OR CREMATORY									
Cedar Hill Cemetery									
23d. LOCATION CITY OR TOWN COUNTY STATE									
Suitland PG Md									
24. FUNERAL DIRECTOR NAME									
Robert E. Wilhelm									
ADDRESS									
Funeral Home Inc Suitland, Md									
25a. DATE REC'D BY REGISTRAR									
MAY 9 1980									
25b. REGISTRAR'S SIGNATURE									
[Signature]									

BP



University of Iowa  
Department of Chemistry

Very truly yours,  
J. H. H. H.

12/1/21  
J. H. H. H.  
12/1/21

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 2 0 7  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Margarette M. Brown</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>05-31-80</b>			2b. HOUR <b>5:40 PM</b>				
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>5-12-93</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KENTUCKY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3306 NILES STREET</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>VICTOR</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE <b>ELIZABETH ARCHDEACON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>233-42-9056</b>		17 INFORMANT ADDRESS <b>JOSEPH E. BROWN SAME AS 13 SON</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arterio sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>18 yrs</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Coronary atherosclerosis, Atrial fibrillation, Hypertension</b>										
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>78 31 May 80</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>8 May 80</b> to <b>31 May 80</b> , that (we) last saw the deceased alive on <b>8 May 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Walter L. White, MD</b>			DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>31 May 80</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Walter L. White, MD</b>			22e. ADDRESS <b>9911 George Ave Silver Spring, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6/3/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 3 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Rita McCreedy</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



KENTUCKY  
 WHITE  
 MONTGOMERY  
 SILVER SPRING  
 3300 WILES STREET  
 HOUSEWIFE

VICTOR  
 MARTIN  
 ELIZABETH  
 ARCHDEACON  
 NO. 123-12-9054  
 JOSEPH E. BROWN  
 SALE AS IS  
 SON

*Handwritten notes and signatures, including "Buried in the ground" and "In the year that falls in the year".*

BURIAL  
 4/2/80  
 FRANCIS J. COLLINS  
 500 WINDY BLVD., SILVER SPRING, MD. 20901  
 DATE OF DEATH  
 SILVER SPRING  
 MONT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 3 2 0 8	
1 - FOR STATE REGISTRAR										CERTIFICATE OF DEATH	
1 DECEASED NAME (TYPE OR PRINT)										7a DATE OF DEATH	
FIRST MIDDLE LAST										MONTH DAY YEAR	
2a HOUR										2b HOUR	
3 SEX										4 RACE	
5 DATE OF BIRTH										6 AGE (IN YEARS LAST BIRTHDAY)	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b CITIZEN OF WHAT COUNTRY?	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9 BALTIMORE CITY OR COUNTY OF DEATH	
10 CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b KIND OF BUSINESS OR INDUSTRY	
13a STATE										13b COUNTY	
13c CITY OR TOWN										13d INSIDE CITY LIMITS?	
13e STREET ADDRESS										13f STREET ADDRESS	
14 FATHER'S NAME										15. MOTHER'S MAIDEN NAME	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b SOCIAL SECURITY NO	
17 INFORMANT										ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b):											
DUE TO, OR AS A CONSEQUENCE OF (c):											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21b HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21c PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										21d LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from 5/9/80 to 5/30/80, that (2) we last saw the deceased alive on 5/29/80, and that (3) our opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)										22b SIGNATURE DEGREE	
22c PHYSICIAN'S NAME (TYPE OR PRINT)										22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)										23b DATE	
23c NAME OF CEMETERY OR CREMATORY										23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME										25a DATE REC'D. BY REGISTRAR	
25b REGISTRAR'S SIGNATURE											

7404 15th Avenue  
North  
Tomball, Tex., U.S.A.

1941. 1942. 1943. 1944. 1945. 1946. 1947. 1948. 1949. 1950. 1951. 1952. 1953. 1954. 1955. 1956. 1957. 1958. 1959. 1960. 1961. 1962. 1963. 1964. 1965. 1966. 1967. 1968. 1969. 1970. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 2593. 2594. 2595. 2596. 2597. 2598. 2599. 2600. 2601. 2602. 2603. 2604. 2605. 2606. 2607. 2608. 2609. 2610. 2611. 2612. 2613. 2614. 2615. 2616. 2617. 2618. 2619. 2620. 2621. 2622. 26

Francis J. Collins  
June 2, 1980 - Mt. Desert



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

|   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |   |  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH<br>REG. NO. 8013209   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Annie</u>  |  |  |  |  | FIRST <u>Annie</u> MIDDLE <u>E</u> LAST <u>Byrum</u>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH <u>5</u> DAY <u>31</u> YEAR <u>80</u>   |  |  |  |  | 2b. HOUR<br><u>1:30</u> <sup>AM</sup>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 SEX<br><u>Female</u>  |  |  |  |  | 4 RACE<br><u>White</u>  |  |  |  |  | 5 DATE OF BIRTH<br>MONTH <u>Jan.</u> DAY <u>27</u> YEAR <u>1882</u>  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>98</u> YRS.  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u>   |  |  |  |  | IF UNDER 24 HRS<br>HOURS <u></u> MIN <u></u> |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Virginia</u>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><u>Rockville</u>  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Collingswood Nursing Home</u> |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Claims Examiner</u>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>U.S. Gov't.</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br><u>Md.</u>  |  |  |  |  | 13b. COUNTY<br><u>Montgomery</u>  |  |  |  |  | 13c. CITY OR TOWN<br><u>Gaithersburg</u>   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |  |  |  | 13e. STREET ADDRESS<br><u>9009 Eugene Drive</u>  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <u>William</u> MIDDLE <u></u> LAST <u>Roaten</u>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Jeannette</u> MIDDLE <u></u> LAST <u>Winbon</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><u>577-10-9056</u>  |  |  |  |  | 17 INFORMANT<br><u>Florence L. Cudmore, Daughter.</u>  |  |  |  |  | 13. <u>Same as item</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>   |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 mo</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Cerebral arteriosclerosis</u>  |  |  |  |  |   |  |  |  |  | <u>2 yrs</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| (c) <u>Generalized arteriosclerosis</u>   |  |  |  |  |   |  |  |  |  | <u>10 yrs</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Coronary arteriosclerosis with complete heart block</u>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APR 10</u> 19 <u>80</u> , to <u>May 31</u> 19 <u>80</u> , that (II) (we) last saw the deceased alive on <u>May 30</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (II) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>James R. Moore Jr.</u>   |  |  |  |  |   |  |  |  |  | DEGREE<br><u>MD</u>  |  |  |  |  | 22c. DATE SIGNED<br><u>5-31-80</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>James R. Moore Jr.</u>  |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br><u>207 Brookes Ave Gaithersburg Md.</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  |  |  |  | 23b. DATE<br><u>6/4/1980</u>  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Beaver Hill Cemetery</u>  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Edenton, N.C.</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME <u>Joseph Gawler's Sons Inc</u><br>ADDRESS <u>5130 Wisc. Ave., N.W. Wash., D.C.</u>   |  |  |  |  |   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 6 1980</u>   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |  |  |  |  |  |  |  |  |  |

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 2 1 0

REG. NO.

|  |  |  |   |   |  |   |  |  |  |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Euela Edythe Cameron                |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 16, 1980 |   |  | 2b. HOUR<br>3:15a M   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 25, 1918   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Nebraska                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Clinical Center, NIH, Bethesda, Md. |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House Wife                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>at home                       |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Anne Arundel  |   | 13c. CITY OR TOWN<br>Glen Burnie  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>7677 Harlow Drive, Apt. H. 21061            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Euel E. McKnight                 |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Dickey  |  |   |  | 16. ADDRESS<br>BOX 331   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----   |   | 17. INFORMANT<br>William W. Cameron (Husband)   |  | 18. ADDRESS<br>Sisters, Oregon  |  |  |  |

MEDICAL CERTIFICATION

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>1820<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic endometrial cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 month<br>2 years |  |
|---|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 19, 1980, to May 16, 1980, that <input checked="" type="checkbox"/> (we) lost the deceased alive on May 16, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Bruce A. Silver M.D.  |  |  |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>5/16/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BRUCE A. SILVER  |  |  |  | 22e. ADDRESS<br>The Clinical Center, National Institutes of Health, Bethesda, Md. 20205 |  |  |  |

|   |  |                        |  |  |  |  |  |
|---|--|------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION |  | 23b. DATE<br>5-17-1980 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SUTTLAND, P.G.C. Md. |  |
|---|--|------------------------|--|--|--|--|--|

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>W. W. CHAMBERS CO. RIVERDALE, Md. |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 21 1980 |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |  |
|---|--|--|--|---|--|

• • • • •

APR 1 5 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RELEASED BY MEDICAL EXAMINER

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  | 8 0 1 3 2 1 1   |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR  |  |
| Filippo A. Capobianco   |  |  |  |  |  |  |  |  |  | 5 6 80  |  |
| 3 SEX   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |
| Male  |  |  |  |  |  |  |  |  |  | 10 30 AM  |  |
| 4 RACE  |  |  |  |  |  |  |  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |
| White   |  |  |  |  |  |  |  |  |  | 38  |  |
| 5 DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR   |  |
| MONTH DAY YEAR  |  |  |  |  |  |  |  |  |  | MONTHS DAYS   |  |
| Oct. 4 1941   |  |  |  |  |  |  |  |  |  | HOURS MIN.  |  |
| 6 BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  |  |  |  |  |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |
| Italy   |  |  |  |  |  |  |  |  |  | MONTGOMERY MD.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |
| Resident Visa   |  |  |  |  |  |  |  |  |  | Tailor-James  |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| 10 CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | Pontes  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |  |  |  |  |  |  |  |  |   |  |
| BETHESDA SUBURBAN   |  |  |  |  |  |  |  |  |  |   |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |  |  |   |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  |   |  |
| Md. Mont. Bethesda  |  |  |  |  |  |  |  |  |  |   |  |
| 14 FATHER'S NAME (FIRST MIDDLE LAST)  |  |  |  |  |  |  |  |  |  | 15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                         |  |
| Jennaro Capobianco  |  |  |  |  |  |  |  |  |  | Rosina DeRosa   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  |  |  |  |  |  | 17 INFORMANT  |  |
| None  |  |  |  |  |  |  |  |  |  | Same as above ADDRESS   |  |
| 16b. SOCIAL SECURITY NO.  |  |  |  |  |  |  |  |  |  | 17a. CONCETTA CAPOBIANCO (WIFE)                                     |  |
| 579 86 2442   |  |  |  |  |  |  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)   |  |  |  |  |  |  |  |  |  | 1 day   |  |
| 2028 Bacterial Meningitis   |  |  |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |  |  |  |  |  |  | 6 years   |  |
| Non Hodgkin's Lymphoma  |  |  |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |  |  |   |  |
| Diabetes Mellitus   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |
|   |  |  |  |  |  |  |  |  |  |   |  |
| 20a. AUTOPSY?   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |
|   |  |  |  |  |  |  |  |  |  | P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |
|   |  |  |  |  |  |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1977 to 6 May 1980, that (I) (we) last saw the deceased alive on 6 May 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | 5/7/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS  |  |
| Eugene T. Libore  |  |  |  |  |  |  |  |  |  | 10400 Green Ave. Nementha Md.                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |  |  |  |  |  |  | 23b. DATE   |  |
| Burial  |  |  |  |  |  |  |  |  |  | 5/9/80  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| Gate of Heaven  |  |  |  |  |  |  |  |  |  | S.S. MONT. Md.  |  |
| 24 FUNERAL DIRECTOR NAME  |  |  |  |  |  |  |  |  |  | 25a. DATE OF REGISTRATION   |  |
| Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.   |  |  |  |  |  |  |  |  |  | MAY 5 1980  |  |
| 25b. DATE OF REGISTRATION   |  |  |  |  |  |  |  |  |  | REGISTRAR'S SIGNATURE   |  |
|   |  |  |  |  |  |  |  |  |  | [Signature]   |  |



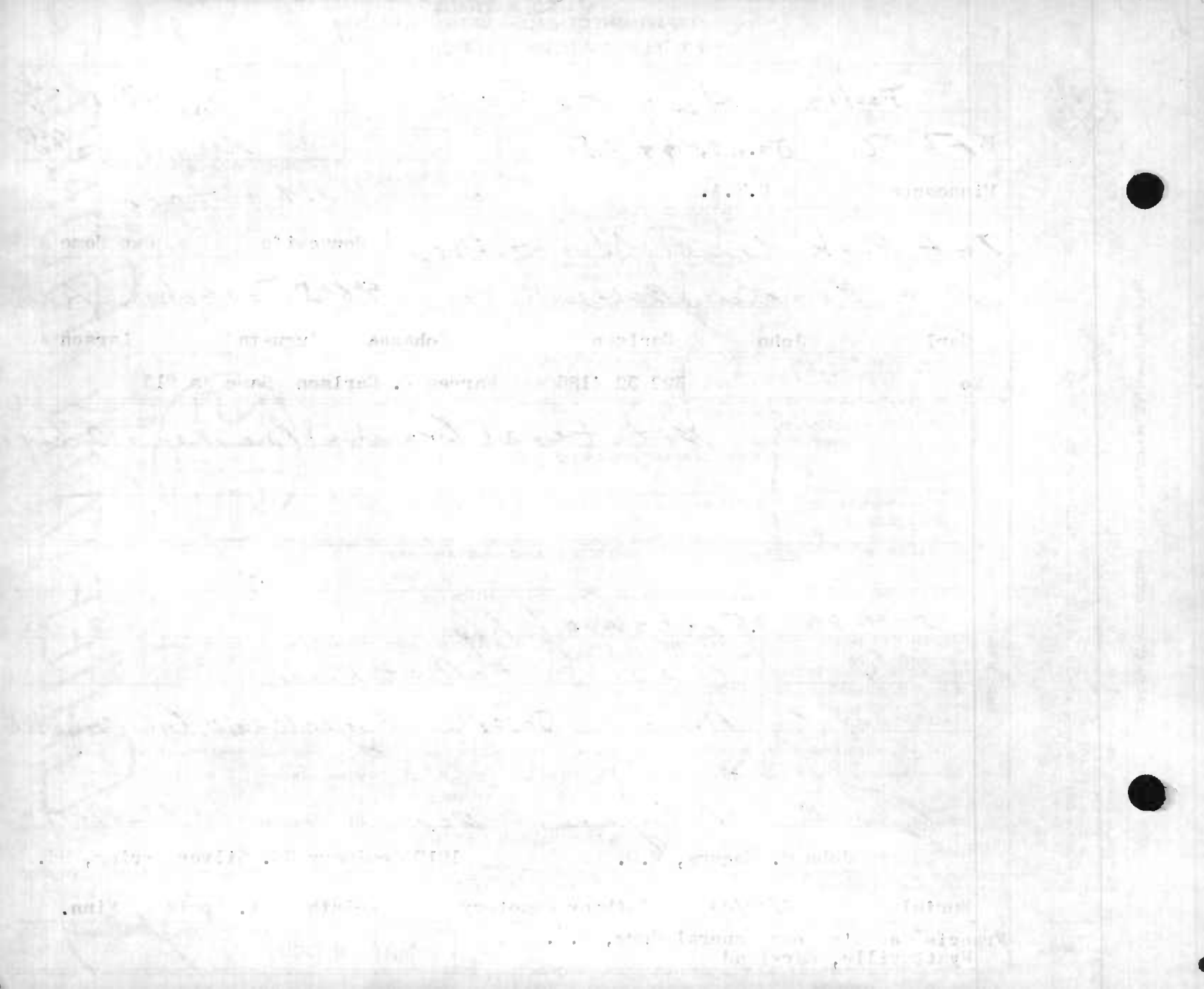
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE MEDICAL EXAMINER. GIVE PAGES 6 AND 7 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
TVR A15 ME (53)  
30M 7/73

| FOR STATE REGISTRAR  |  |         |  |                  |   |                   |  |                |  | FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
|--|--|---------|--|------------------|---|-------------------|--|----------------|--|--|--|--------------------------|--|----------|--|--|--|--|--|-------------------------------|--|--|--|--|
| 1- STATE REGISTRAR   |  |         |  |                  |   |                   |  |                |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |         |  |                  | FIRST MIDDLE LAST   |                   |  |                |  | 2a. DATE KNOWN OF DEATH ESTIMATED  |  |                          |  |          | 2b. HOUR   |  |  |  |  |                               |  |  |  |  |
| JULIA AUGUSTA CARLSON  |  |         |  |                  |   |                   |  |                |  | May 19 1980  |  |                          |  |          | 9:40 PM  |  |  |  |  |                               |  |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (IN YEARS) |  | IF UNDER 1 YR. |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD |  | 7d. HOUR |  |  |  |  |  |                               |  |  |  |  |
| FEMALE   |  | WHITE   |  | Jan. 25, 1895    |   | 85 YRS.           |  |                |  |  |  | May 17 1980              |  | 9:40 PM  |  |  |  |  |  |                               |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  |                  | 7b. CITIZEN OF WHAT COUNTRY?  |                   |  |                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                          |  |          | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |                               |  |  |  |  |
| Minnesota  |  |         |  |                  | U.S.A.  |                   |  |                |  |  |  |                          |  |          | Montgomery MD.   |  |  |  |  |                               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |  |                |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                          |  |          | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                               |  |  |  |  |
| TAKOMA PARK  |  |         |  |                  | Catholic Advent Hosp  |                   |  |                |  | Housewife  |  |                          |  |          | Own Home   |  |  |  |  |                               |  |  |  |  |
| 13a. STATE   |  |         |  |                  | 13b. COUNTY   |                   |  |                |  | 13c. CITY OR TOWN  |  |                          |  |          | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET ADDRESS           |  |  |  |  |
| Md   |  |         |  |                  | Prince George's   |                   |  |                |  | Beltville  |  |                          |  |          | 4506 Josephine Ave   |  |  |  |  |                               |  |  |  |  |
| 14. FATHER'S NAME  |  |         |  |                  | 15. MOTHER'S MAIDEN NAME  |                   |  |                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |                          |  |          | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT ADDRESS         |  |  |  |  |
| Carl John Carlson  |  |         |  |                  | Johanna Augusta Larson  |                   |  |                |  | No   |  |                          |  |          | 322 32 4186  |  |  |  |  | Warren E. Carlson Same as #13 |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                               |  |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Bilateral Bronchial Pneumonia</u>   |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |          | 2 days   |  |  |  |  |                               |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| (b)  |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| (c)  |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                   |  |                |  |  |  |                          |  |          | 20. AUTOPSY?   |  |  |  |  |                               |  |  |  |  |
| 5-4-80   |  |         |  |                  | Femoral head / hip  |                   |  |                |  |  |  |                          |  |          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |  |  |  |                               |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |  |         |  |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |                   |  |                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
|  |  |         |  |                  | PM 5:30 1980  |                   |  |                |  | Fell at home   |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |         |  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                   |  |                |  | 21f. LOCATION  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
|  |  |         |  |                  | Home  |                   |  |                |  | Josephine Ave Beltville Prince George's Md.  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |                  |   |                   |  |                |  |  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| ACTUAL SIGNATURE   |  |         |  |                  | TITLE (SPECIFY)   |                   |  |                |  | DATE SIGNED  |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| John S. Rogers, M.D.   |  |         |  |                  | M.D. Rep.   |                   |  |                |  | MEDICAL EXAMINER   |  |                          |  |          | May 17 1980  |  |  |  |  |                               |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  |                  | ADDRESS   |                   |  |                |  | 1919 Seminary Rd. Silver Spring, Md.   |  |                          |  |          |  |  |  |  |  |                               |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  |                  | 23b. DATE   |                   |  |                |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                          |  |          | 23d. LOCATION  |  |  |  |  |                               |  |  |  |  |
| Burial   |  |         |  |                  | 5/22/80   |                   |  |                |  | Bethany Cemetery   |  |                          |  |          | Deluth St. Louis Minn.   |  |  |  |  |                               |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  |                  |   |                   |  |                |  | 25a. DATE REC'D. BY REGISTRAR  |  |                          |  |          |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE    |  |  |  |  |
| Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland  |  |         |  |                  |   |                   |  |                |  | MAY 20 1980  |  |                          |  |          |  |  |  |  |  | [Signature]                   |  |  |  |  |





| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |  |   |   |   |   |  |   |  | REG. NO. 13213  |  |   |  |
|---|----------------------|--|---|---|---|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William S Carroll</b>  |                      |  |   |   |   |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>May 29, 1980</b>  |  |   |  |
| 3. SEX<br><b>M.</b>   | 4. RACE<br><b>W.</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 28, 1907</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>73</b> RS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>May 29, 1980</b>                 |  | 2d. HOUR<br><b>11:25</b> AM   |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash., D.C.</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                     |  |   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3808 Woodbine St.</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Counselor</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Investment</b>                              |  |   |  |   |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Montg.</b> 13c. CITY OR TOWN <b>Chevy Chase</b>   |                      |  |   |   |   |   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3808 Woodbine St.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Not available</b>  |                      |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Not available</b> |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>   |                      | 16b. SOCIAL SECURITY NO.<br><b>216-46-3417</b>   |   | 17. INFORMANT<br><b>800 1<sup>st</sup> Ave. St. N.W. Kenneth Foster, Jr. Wash., D.C.</b>  |   |   |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gun shot wound of head.</b><br>9550<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Self-Inflicted.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                      |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| 19a. DATE OF OPERATION  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11:35 AM 5-27-1980</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Shot self in mouth with hand gun.</b>                                   |   |   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>6808 Woodbine St. Chcl- Montgomery Md.</b>  |   |   |  |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .                     |                      |  |   |   |   |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>   |                      | TITLE (SPECIFY)<br><b>Deputy</b>   |   | MEDICAL EXAMINER<br><b>7936 Old Georgetown Rd. Bethesda, Md.</b>  |   | DATE SIGNED<br><b>May 29, 1980</b>  |  |   |  |   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John G. Ball</b>  |                      | ADDRESS  |   |   |   |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |                      | 23b. DATE<br><b>May 31, 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria, Va.</b>              |  |   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A.</b>   |                      | ADDRESS<br><b>Bethesda, Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 4 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                  |  |   |  |   |  |   |  |

Not available  
100-45-1117 Kenneth E. Smith, Jr.  
100-45-1117 Kenneth E. Smith, Jr.  
100-45-1117 Kenneth E. Smith, Jr.

James, L. . . .  
Robert A. . . .  
Creation May 31, 1960  
John D. Smith

Alameda, L. . . .  
100-45-1117 Kenneth E. Smith, Jr.  
100-45-1117 Kenneth E. Smith, Jr.

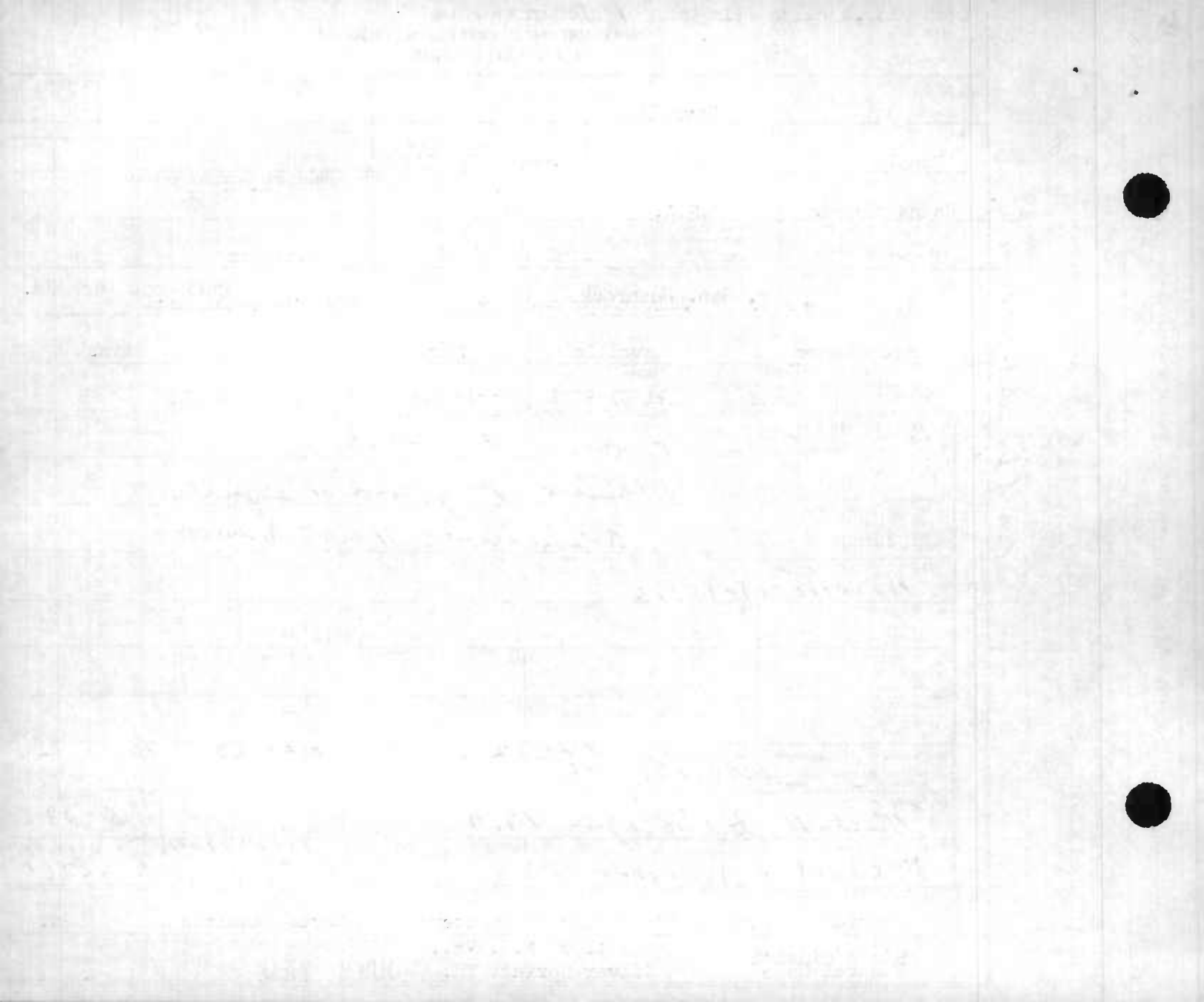
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared by med. Examiner

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   | REG. NO.   |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary Havrilla Chalfa   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 23, 1980  |  | 2b. HOUR<br>7:30AM   |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Nov. 7, 1989   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>80 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Olney   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                      |  |
| 13a. STATE<br>Md.  |   | 13b. CITY OR TOWN<br>Silver Spring  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>9503 Good Luck Rd.<br>1612 Gamewell Road                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Bartholemew Havrilla  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Raynak   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>None  | 17. INFORMANT ADDRESS<br>Marie Detwiler Same As #13   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>410 - DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerosis Heart Disease</u> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Arteriosclerosis</u>  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>MAY 22</u> , 19 <u>80</u> , to <u>MAY 23</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>MAY 23</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Michael A. Bolognese</u>  |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>5-23-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael A. Bolognese M.D.   |   | 22e. ADDRESS<br>19261 Montgomery Village Ave<br>Gaithersburg, Md. 20860   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>May 27, 1980   | 23c. NAME OF CEMETERY OR CREMATORY<br>Calvary Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>North Hazelton Pa.  |
| 24. FUNERAL DIRECTOR NAME<br>Hines/Rinaldi Funeral Home  |   | ADDRESS<br>11800 N.H.AVE., Silver Spring, Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 2 1980                                    | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McBrady</u>   |

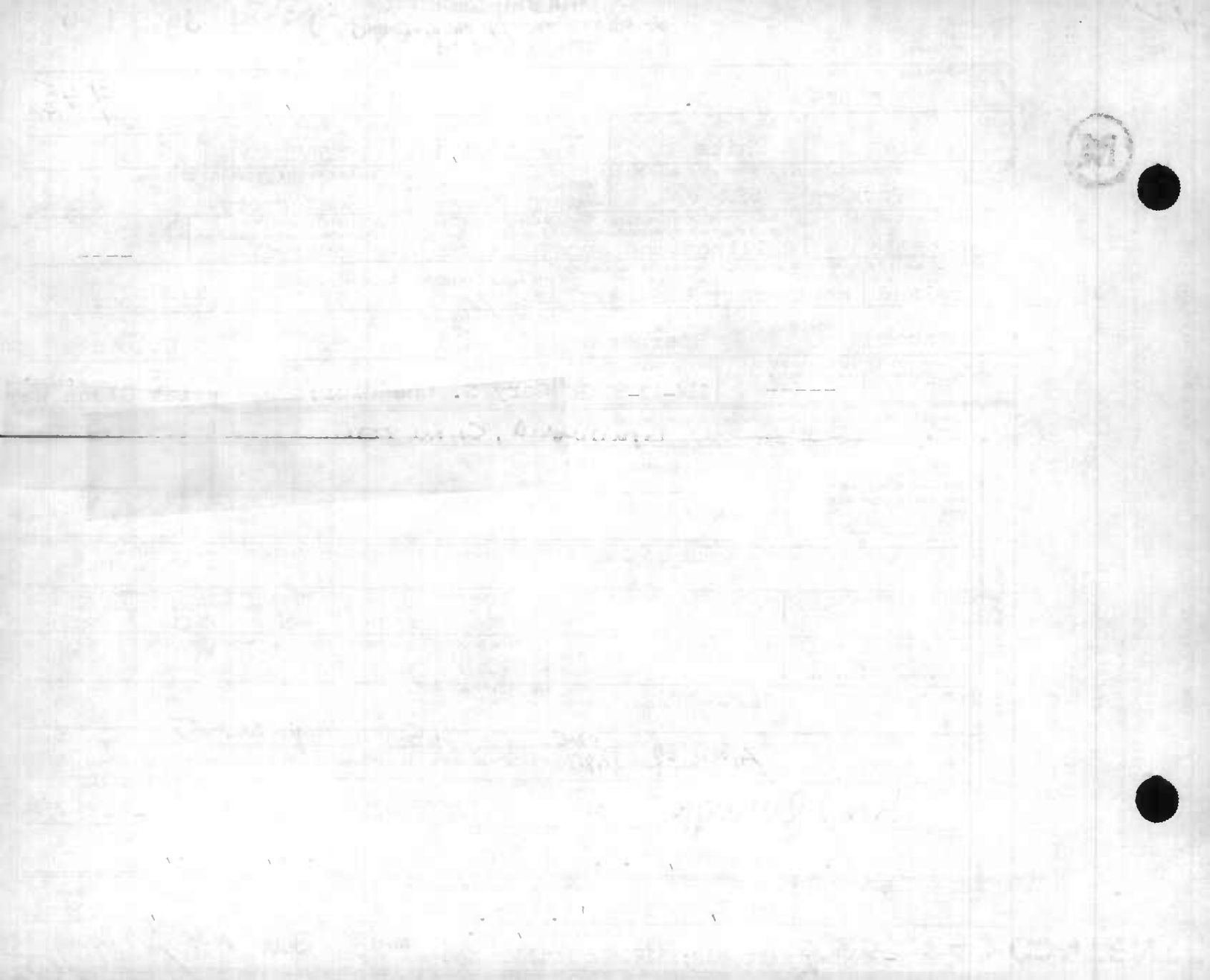


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |                       |  |  | REG. NO. 13215                               |  |
|--|--|--|--|--|--|--|-----------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HELEN S. CHANDLER   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 5, 1980 |  | 2b. HOUR<br>9:45 A.M. |  |  |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>April 21, 1915  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS   |                       | 7 UNDER 1 YEAR<br>MONTHS DAYS  |  | 7 UNDER 24 HRS<br>HOURS MIN                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                                 |                       |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Rockville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Collingswood Nursing Home |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |                       | 12b. KIND OF BUSINESS OR INDUSTRY<br>----  |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Gaithersburg  |  | 13d. INSIDE CITY LIMITS?<br>NO <input type="checkbox"/>                              |                       | 13e. STREET ADDRESS<br>19537 Gallatin Court  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jacob Sperber   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Celia Golden  |  |  |                       |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>114-12-3932W   |  | 17 INFORMANT<br>GARY S. CHANDLER   |  |  |                       | ADDRESS<br>Gaithersburg, Md.<br>9534 Briar Glenn Way   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Liver tumor, small cell</u><br><u>2008</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |                       |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |                       |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                       |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                       |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1965</u> to <u>present</u> , that (I) (we) lost <u>her</u> above, (I) (we) (did) (did not) view the body after death. <u>1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |  |  |  |  |  |                       |  |  |  |  |
| 22b. SIGNATURE<br><u>Jack J. Rheingold</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |  |                       | 22c. DATE SIGNED<br>5-5-80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JACK J. RHEINGOLD, M.D.   |  |  |  | 22e. ADDRESS<br>2201 L Street N.W., Wash., DC  |  |  |                       |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>May 7, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Nat'l. Mem. Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Falls Church, Virginia                 |                       |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Danzansky-Goldberg Chapels  |  |  |  | ADDRESS<br>1170 Rockville Pike   |  | 25a. DATE REC'D BY REGISTRAR<br>MAY 9 1980   |                       | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Brady</u>   |  |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **8 0 1 3 2 1 6**  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |   |  |  |   |  |  |
|--|--|---|---|--|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>EARL T. CHANNELL</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 10, 1980</b>             |  |   | 2b HOUR<br><b>1:45</b><br>A M  |  |   |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 16, 1909</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b><br>YRS.  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><b>11 11</b>   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.   |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor of Contracts</b>  |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>FAA</b>   |  |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>  |  |   | 13b COUNTY<br><b>MONTGOMERY</b>                                       |  | 13c CITY OR TOWN<br><b>SILVER SPRING</b>                      |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS<br><b>9805 DILSTON ROAD</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GROVER CLINTON CHANNELL</b>  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DORA TALBOTT</b>   |  |   |  |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b SOCIAL SECURITY NO<br><b>220-42-0075</b>                          |  | 17 INFORMANT<br><b>VERA P. CHANNELL</b>                       |  |  |   | ADDRESS<br><b>SAME AS 13 WIFE</b>              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |   |  |  |   |  |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>April 17, 1980</b> to <b>May 10, 1980</b> , that (I) (we) lost saw the deceased alive on <b>May 10, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |   |  |  |   |  |  |
| 22b SIGNATURE<br><b>Raymond Bradshaw, MD</b>   |  |   | DEGREE  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>May 10, 1980</b>  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Raymond Bradshaw</b>  |  |   | 22e ADDRESS<br><b>345 University Blvd, W.<br/>Silver Spring, Md.</b>  |  |   |  |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   | 23b DATE<br><b>5/13/80</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>GEORGE WASHINGTON</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ADELPHI PRI GEO MD</b>                         |   |  |  |
| 24 FUNERAL DIRECTOR<br><b>FRANCIS J. COLLINS</b><br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |   |   |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>MAY 15 1980</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Robert Keating</b>  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

300 UNIT. BLVD. W. SILVER SPRING, MD. 20901  
FRANKS & COLLINS  
5/13/80  
GEORGE WASHINGTON  
ARLINGTON  
FRI GEO  
MD.

NO. 320-12-0075  
TERRY P. CHAMMELL  
SALES IS  
RTE  
GROWER  
CLINTON CHAMMELL  
DORA  
TALBOTT  
MONTGOMERY  
SILVER SPRING  
X  
9825 DILLON ROAD  
SILVER SPRING  
HOLY CROSS HOSPITAL  
SUPERVISOR of CONTRACTS  
FVA  
WEST VIRGINIA  
N.S.A.  
WHITE  
APRIL 14, 1980  
71

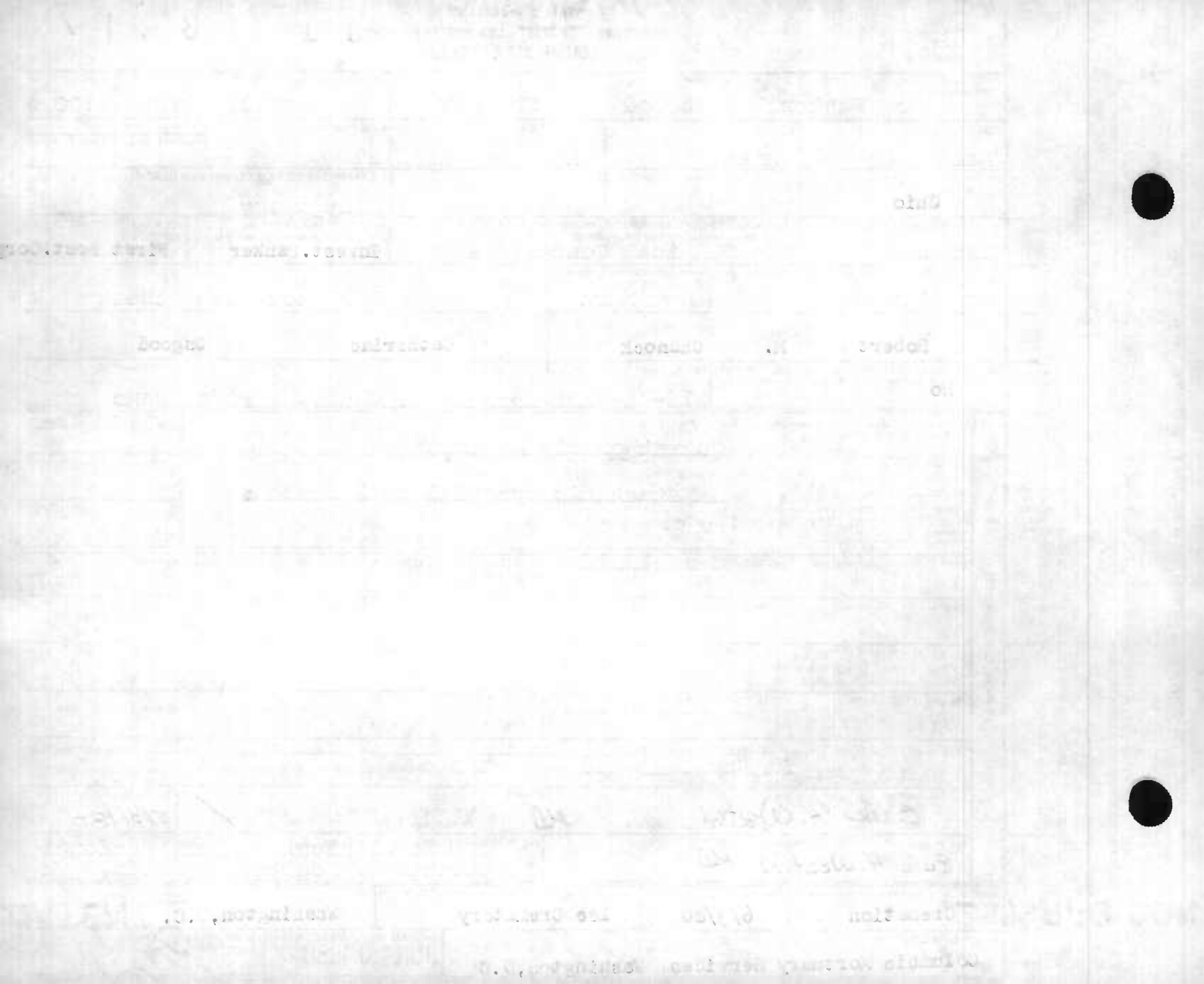
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |  |  |   | 7 0 1 3 2 1 7  |   |
|--|---|--|--|---|--|---|
| 1. FOR<br>STATE<br>REGISTRAR   |   |  | REG. NO.   |   |  |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Foster Osgood Chanock  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 31, 1980                                |   | 2b. HOUR<br>6:00 A   |   |
| 3 SEX<br>Male  | 4 RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 06 1952   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>27 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Clinical Center, NIH |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Invest. Banker |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>First Bost. Corp.   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>New York  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>New York  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>299 West 12th Street  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert M. Chanock  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Osgood                  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>216-46-1131  |  | 17. INFORMANT ADDRESS<br>Dorothy C. Chanock, wife, same   |  |   |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Intrathoracic hemorrhage</u><br>1719<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic synovial cell sarcoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (X) this hospital attended the deceased from <u>14 May</u> , 19 <u>80</u> , to <u>31 May</u> , 19 <u>80</u> , that (X) (we) lost<br>saw the deceased alive on <u>31 May</u> , 19 <u>80</u> , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (X) (we) (did) (did not) view the body after death.   |   |  |  |   |  |   |
| 22b. SIGNATURE<br>Eric H. Westin MD  |   |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>5/31/80                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Eric H. Westin MD   |   |  |  | 22e. ADDRESS<br>The Clinical Center, National<br>Institutes of Health, Bethesda, Md             |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |   | 23b. DATE<br>6/3/80  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lee Crematory                                |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C.   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Columbia Mortuary Services   |   |  |  | ADDRESS<br>Washington, D.C.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 10 1980    |
|  |   |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]       |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |  |  | GORDON L. CLARK  |   |
|---|---|--|--|--|---|
| FOR<br>1 - STATE<br>REGISTRAR   |   |  |  | REG. NO.   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Gordon L. Clark</u>   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>05-012-1980</u>   |  | 2b. HOUR<br><u>4:30 P.M.</u>                              |
| 3 SEX<br><u>Male.</u>   | 4 RACE<br><u>White.</u>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>Feb. 2, 1907</u>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><u>73</u> YRS  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Everett, Mass.</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery.</u> MD.                              |   |
| 10 CITY OR TOWN OF DEATH<br><u>Takoma Park.</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Washington Adventist Hospital.</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Elec. Engineer Fed. Govt</u> | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><u>Maryland.</u>  |   | 13b. COUNTY<br><u>Montgomery</u>   | 13c. CITY OR TOWN<br><u>Takoma Park.</u>   | 13d. STREET ADDRESS<br><u>7208 Central Ave.</u>  |   |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><u>Warren Clark</u>   |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Caroline Evans.</u>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><u>Yes.</u>           |   |
| 16b. SOCIAL SECURITY NO.<br><u>015-12-8296</u>  |   | 17 INFORMANT<br><u>Roselle Q. Clark.</u>   |  | ADDRESS<br><u>13 e</u>   |   |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Massive CVA</u><br><u>4029</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ACVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 weeks</u><br><u>10 yrs.</u><br><u>3 weeks</u> |   |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>arteriosclerosis - Plural effusion</u>  |   |  |  |  |   |
| 19a. DATE OF OPERATION<br><u>—</u>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>—</u>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>—</u> P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>—</u> |   |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>—</u>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><u>—</u>                                 |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Jan 19, 1978</u> to <u>May 12, 1980</u> , that (2) (we) last saw the deceased alive on <u>May 11, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.   |   |  |  |  |   |
| 22b. SIGNATURE<br><u>R. H. Sandstrom MD</u>   |   | DEGREE<br><u>M.D.</u>  |  | 22c. DATE SIGNED<br><u>5-12-80</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>R. H. Sandstrom MD</u>  |   | 22e. ADDRESS<br><u>9701 Carroll Ave Takoma Park, Md</u>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial.</u>   |   | 23b. DATE<br><u>MAY 15, 1980</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn.</u>                                     |   |
| 23d. LOCATION (CITY OR TOWN)<br><u>White Co. Md.</u>  |   | 23e. STATE<br><u>Md.</u>   |  |  |   |
| 24. FUNERAL DIRECTOR<br><u>Arthur Walters</u>   |   | 24b. ADDRESS<br><u>254 Carroll St NW Washington D.C. 20012</u>   |  | 25. DATE REC'D. BY REGISTRAR<br><u>5-13-80</u>   |   |

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• **Victims' Rights**

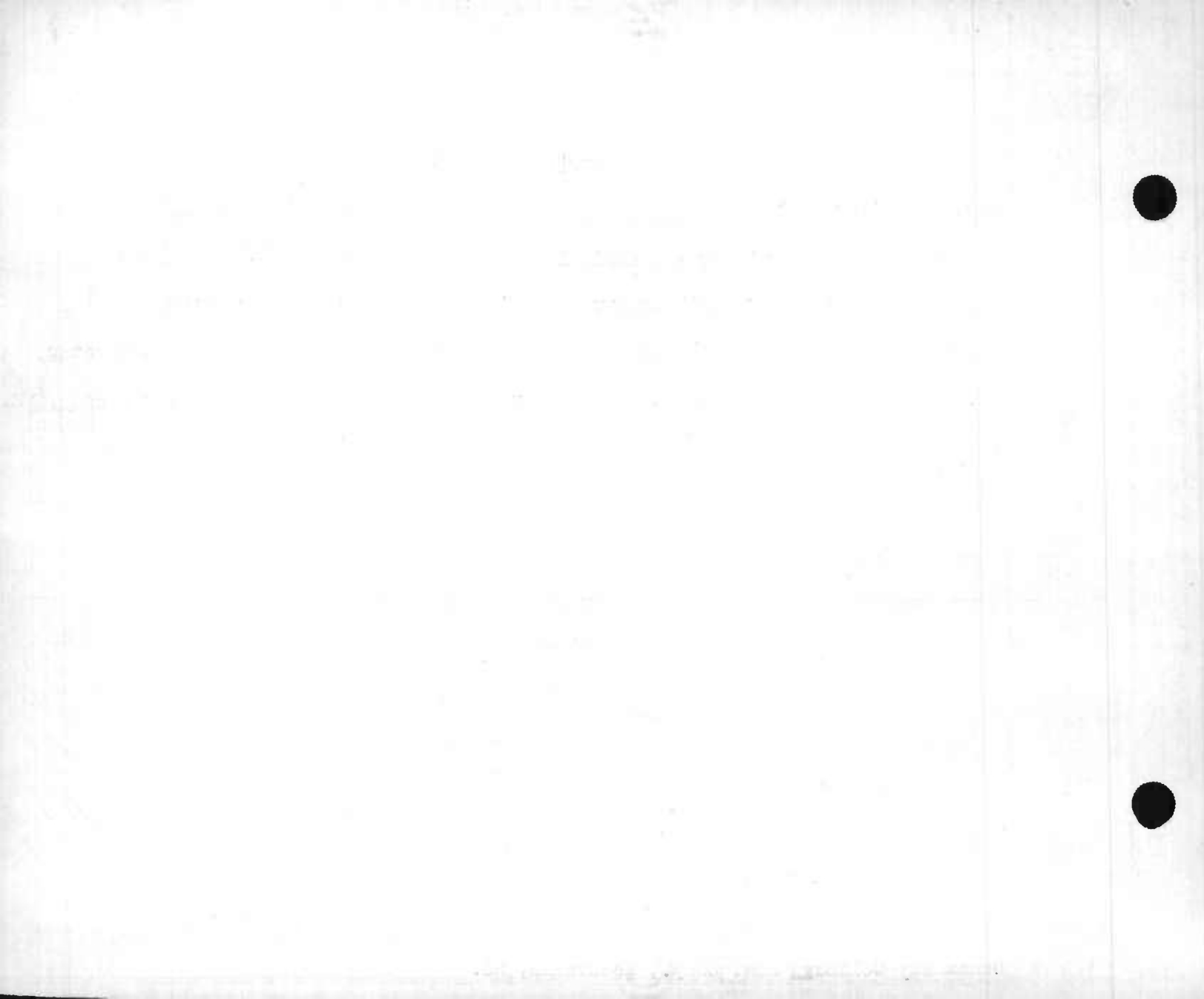
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |   |   |  |  |   | 8  | 0   | 1  | 3   | 2                                | 1  | 9 |
|---|--|--|---|--|---|---|--|--|---|--|---|--|---|----------------------------------|--|---|
| 1- FOR STATE REGISTRAR  |  |  |   |  |   |   |  |  |   | REG. NO.   |   |  |   |                                  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>David Jonathan Cohen  |  |  |   |  |   |   |  |  |   | 2a. DATE OF DEATH<br>5-21-80   |   |  |   | 2b. HOUR<br>4P. M.               |  |   |
| 3. SEX<br>Male  |  |  | 4. RACE<br>Caucasian  |  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 6, 1953   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>26 YRS.  |  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Dist. of Columbia  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Holtzman MD.  |  |   |  |   |                                  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |   |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Never Worked        |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None |                                  |  |   |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>Montgomery   |  |   | 13c. CITY OR TOWN<br>Silver Spring  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2600 Baywood Court |  |   |                                  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gerald --- Cohen  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dorothy --- Canchester |   |  |  |   |  |   |  |   |                                  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A          |   |  |  |   | 17. INFORMANT ADDRESS<br>Gerald Cohen, 2600 Baywood, Silver Spring, Md.              |   |  |   |                                  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u><br>911-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION FOOD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |   |   |  |  |   |  |   |  |   |                                  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>multiple BIRTH MORTALITIES</u>  |  |  |   |  |   |   |  |  |   |  |   |  |   |                                  |  |   |
| 19a. DATE OF OPERATION  |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   |  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |  |   |                                  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |   |  |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |                                  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>5-21</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)  |  |  |   |  |   |   |  |  |   |  |   |  |   |                                  |  |   |
| 22b. SIGNATURE<br><u>Robert Kramer M.D.</u>   |  |  |   |  |   |   |  |  |   | DEGREE   |   | 22c. DATE SIGNED<br><u>5/24/80</u>   |   |                                  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Kramer, M. D.   |  |  |   |  |   |   |  |  |   | 22e. ADDRESS<br><u>8630 FERTON ST SILVER SPRING</u>                                  |   |  |   |                                  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |   |  | 23b. DATE<br>5-25-80  |   |  |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Hebron Cemetery                            |   |  |   |                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Queens, New York |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Danzansky-Goldberg Mem. Chap., Rockville, Md.   |  |  |   |  |   |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 28 1980   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |                                  |  |   |





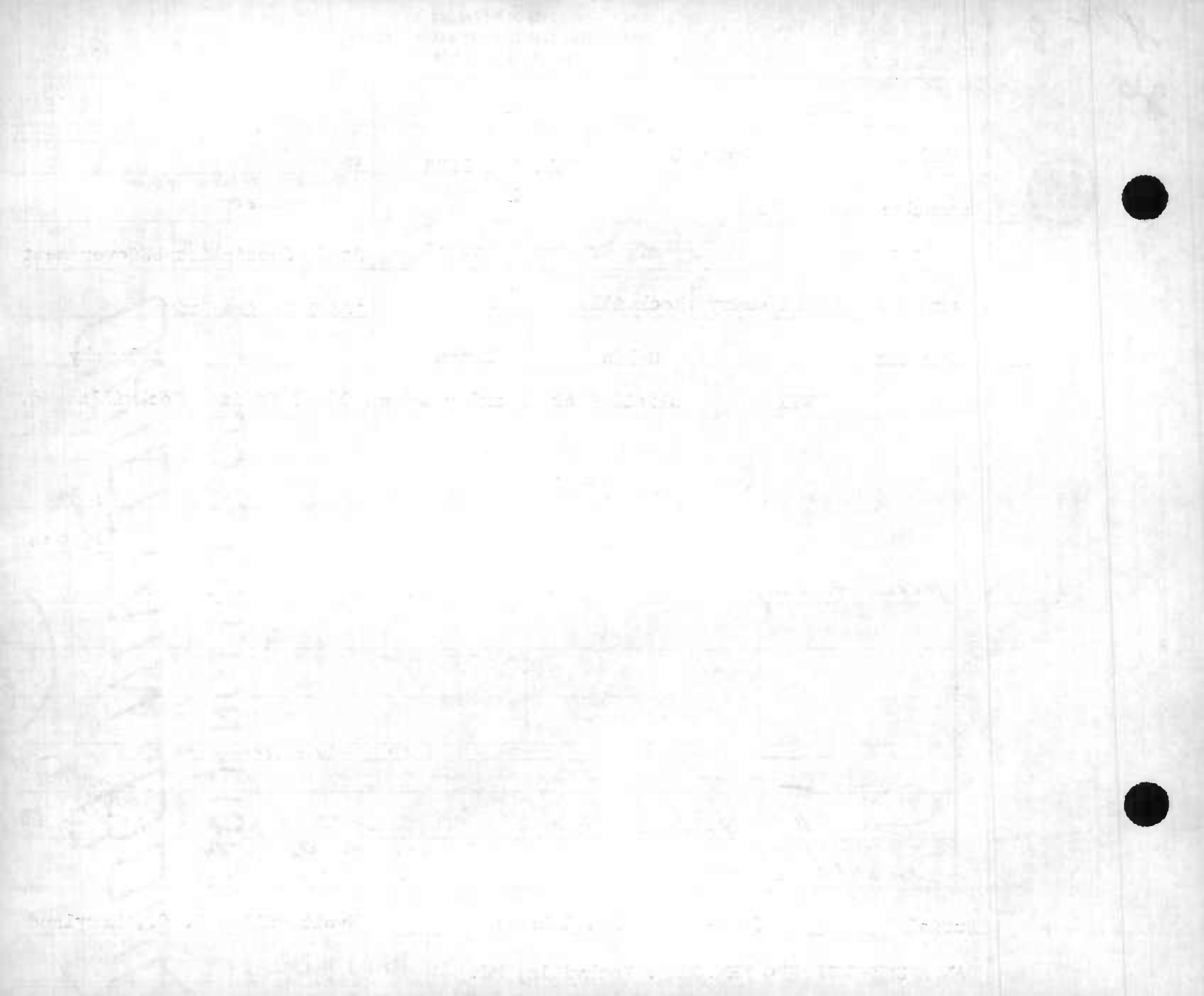
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. Page 3 should be filed with the funeral home after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |   |  |   |   |  | 8 0 1 3 2 2 0 |  |
|---|--|--|--|--|---|--|---|---|--|---------------|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  |   |  |   |   |  | REG. NO.      |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Jacob Cohen</b>  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 15, 1980</b>                 |  |   | 2b. HOUR<br><b>8:12AM</b>                                       |  |               |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 21, 1922</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Massachusetts</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |   |   |  |               |  |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Staff Specialist</b>                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US Government</b>       |  |               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |  |  | 13b. CITY OR TOWN<br><b>Montgomery</b>                                  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>14607 Nadine Drive</b> |               |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Barnett --- Cohen</b>  |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rachel --- Belansky</b> |  |   |   |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WWII</b>  |  | 17 INFORMANT ADDRESS<br><b>Shirley Cohen, 14607 Nadine, Rockville, Md.</b>   |   |  |   |   |  |               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>liver failure</u><br>1539 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Metastatic cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF } (c) <u>Adenocarcinoma of colon</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 mo</u><br><u>1 1/2 yrs</u><br><u>3 1/2 yrs</u> |  |  |  |  |   |  |   |   |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Metas. to lungs, portal hypertension, varices, splenomegaly</u>  |  |  |  |  |   |  |   |   |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |  |               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |               |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>14 May</u> 19 <u>80</u> to <u>15 May</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>14 May</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |   |   |  |               |  |
| 22b. SIGNATURE<br><u>Donald E. Dillon</u> M.D.  |  |  |  | DEGREE   |   | 22c. DATE SIGNED<br><u>15 May 80</u>   |   |   |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Donald E. Dillon, M.D.</u>  |  |  |  | 22e. ADDRESS<br><u>18111 R. Philip Dr<br/>Olney, Md 20832</u>  |   |  |   |   |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-16-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Lebanon</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Hyattsville, P. G., Maryland</b>   |   |   |  |               |  |
| 24. FUNERAL DIRECTOR NAME<br><b>DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 19 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>History McCreedy</u>  |   |   |  |               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |  | REG. NO.   |  |
|---|--|--|--|--|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |   |  |  |  |  | 8013221  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST <u>LEE</u> MIDDLE <u>T</u> LAST <u>COHEN</u>  |  |  |  |  | 2a. DATE OF DEATH MONTH <u>MAY</u> DAY <u>31</u> YEAR <u>1980</u>           |  |  | 2b. HOUR <u>4:00</u> P. M.   |  |  |  |
| 3 SEX<br><u>Female</u>  |  | 4 RACE<br><u>CAUCASIAN</u>   |  | 5. DATE OF BIRTH MONTH <u>JULY</u> DAY <u>24</u> YEAR <u>1896</u>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><u>83</u> YRS.                                     |  | 7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>   |  | 8. IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>D.C.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>MONTGOMERY CO.</u> MD.                     |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><u>WHEATON</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>UNIVERSITY NURSING HOME</u> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Homemaker</u>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |   |  |  |  |  |  |  |
| 13a. STATE<br><u>Md.</u>  |  | 13b. COUNTY<br><u>Montgomery</u>   |  | 13c. CITY OR TOWN<br><u>Kensington</u>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>3928 Washington St.</u>  |  |  |  |
| 14 FATHER'S NAME FIRST <u>Winfield</u> MIDDLE <u>S</u> LAST <u>Towers</u>   |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST <u>Lee</u> MIDDLE <u></u> LAST <u>Lenthol</u> |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><u>No</u>  |  | 16b. SOCIAL SECURITY NO<br><u>213-46-9200</u>  |  | 17 INFORMANT ADDRESS<br><u>William B. Cohen, Son. Same as item 13.</u>   |   |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastric Hemorrhage</u><br>5314<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Gastric Ulceration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br><u>12 hours</u><br><u>12 hours</u> |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>12 hours</u><br><u>12 hours</u> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Multiple Central Thromboses. Identifiable from lesions</u>   |  |  |  |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |  |  |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Oct. 9-26</u> 19 <u>80</u> to <u>May 31</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9-26</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Lincoln T. Kimble M.D.</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   |  |  | 22c. DATE SIGNED<br><u>5-31-80</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>S. T. KIMBLE M.D.</u>   |  |  |  | 22e. ADDRESS<br><u>9801 Georgia Avenue, Silver Spring, Md.</u>   |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Cremation</u>   |  | 23b. DATE<br><u>6/2/1980</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Crematory</u>  |   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Suitland, Maryland.</u>  |  |  |  |
| 24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc</u><br>NAME ADDRESS<br><u>5130 Wisconsin Ave., N.W. Wash., D.C.</u>   |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 6 1980</u>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |   |  |  |   |  |  |  |
|---|--|--|--|--|--|---|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 8 0 1 3 2 2 2  |   |   |  |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  | REG. NO.   |   |   |  |  |   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>HERMAN</b>   |  |  | FIRST<br><b>L.</b>   |  | MIDDLE<br><b>Coldiron</b>  |   | LAST<br><b>Coldiron</b>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 - 29 - 80</b>  |   | 2b HOUR<br><b>9 48</b> AM                              |  |  |
| 3 SEX<br><b>Male</b>  |  |  | 4 RACE<br><b>Caucasian</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 20, 1921</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>59</b>  |   | IF UNDER 74 HRS<br>HOURS MIN.<br><b>59</b>             |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>   |  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                 |  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Contractor</b>   |   |   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Painting</b>  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>   |  |  |  |  | 13b COUNTY<br><b>Frederick</b>   |   | 13c CITY OR TOWN<br><b>Monrovia</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |   | 13e STREET ADDRESS<br><b>Rt. 1 22 White Pine Drive</b> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lee C. Coldiron</b>   |  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Hamilton</b>   |   |   |  |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  |  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>Katherine B. Coldiron, Same as #13</b>                |  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>4341</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>arterio stenosis</b>                                      |  |  |  |  |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 MIN</b><br><b>4 DAYS</b><br><b>20 YEARS</b> |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic active hepatitis &amp; cholecystitis</b>   |  |  |  |  |  |   |   |  |  |   |  |  |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>JULY 15, 1961</b> to <b>MAY 24, 1980</b> , that (I) last lost<br>saw the deceased alive on <b>MAY 29, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |  |  |   |  |  |  |
| 22b SIGNATURE<br><b>Thomas F. O'Connor MD</b>   |  |  |  |  | DEGREE<br><b>MD</b>  |   |   |  |  | 22c DATE SIGNED<br><b>MAY 29, 1980</b>  |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS F. O'CONNOR MD</b>  |  |  |  |  | 22e ADDRESS<br><b>5218 WISCONSIN AVE, BETHESDA</b>   |   |   |  |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b DATE<br><b>6/3/80</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Highland Memorial</b>  |   |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Knoxville, Tennessee</b> |  |   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey Funeral</b>  |  |  |  |  | 24b ADDRESS<br><b>Homes, P.A. Bethesda, Maryland</b>   |   |   | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 4 1980</b>                        |  | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

1502 • J. Neurosci., July 26, 2006 • 26(30):1497–1504



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 1 3 2 2 3  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Louise Adams CONLYN  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>May 21 1980   |  | 2b HOUR<br>1:30A AM  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Caucasian  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>March 1 1923   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington D.C.  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE 13b COUNTY 13c CITY OR TOWN<br>Maryland Calvert Prince Frederick  |  |  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e STREET ADDRESS<br>Box 146, Route 1   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Samuel Webster Adams   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Emma Louise Conner  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>577-48-9732   |  | 17 INFORMANT ADDRESS<br>Robert M. Conlyn See item 13   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>1830<br>DUE TO, OR AS A CONSEQUENCE OF <u>Adenocarcinoma of ovary</u><br>(b) <u>metastatic</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>April 8</u> 19 <u>80</u> , to <u>May 21</u> 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>May 21</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                 |  |  |  |  |  |  |  |
| 22b SIGNATURE<br><u>GARY W SMITH M.D.</u><br>22b PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c DATE SIGNED<br>May 21 1980   |  |
| 22d ADDRESS<br>National Naval Medical Center, Bethesda, Md,  |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b DATE<br>5/22/80  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory Alexandria Virginia  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24 FUNERAL DIRECTOR NAME<br>Borgwardt  |  |  |  | 24b ADDRESS<br>Funeral Home Port Republic, Md.   |  | 25a DATE REC'D. BY REGISTRAR<br>MAY 26 1980  |  |
|  |  |  |  | 25b REGISTRAR'S SIGNATURE<br><u>P. K. McReady</u>  |  |  |  |

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Estimated amount of cargo  
to be received at  
the end of the month

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |  |  |  |  |   | 8  | 0 | 1                        | 3        | 2 | 2              | 4     |       |      |   |      |  |          |  |
|---|--|--|---|--|--|--|--|--|---|--|---|--------------------------|----------|---|----------------|-------|-------|------|---|------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |                          | REG. NO. |   |                |       |       |      |   |      |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   |  |  | MIDDLE   |  |  | LAST  |  |   | 2a. DATE OF DEATH        |          |   |                | MONTH |       | DAY  |   | YEAR |  | 2b. HOUR |  |
| Margaret  |  |  | L.  |  |  | CONNOR   |  |  | May   |  |   |                          | 11       |   | 1980           |       | 1152A |      | M |      |  |          |  |
| 3 SEX   |  |  | 4 RACE  |  |  | 5 DATE OF BIRTH  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  |   | 7 UNDER 1 YEAR           |          |   | 7 UNDER 24 HRS |       |       |      |   |      |  |          |  |
| Female  |  |  | Caucasian   |  |  | June 29 1919   |  |  | 60  |  |   | YRS                      |          |   | MONTHS         |       |       | DAYS |   |      |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| Minnesota   |  |  | USA   |  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | Montgomery  |  |   |                          |          |   |                |       |       | MD   |   |      |  |          |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| Bethesda  |  |  | National Naval Medical Center   |  |  | Teacher  |  |  | Education   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |   | 13e. STREET ADDRESS      |          |   |                |       |       |      |   |      |  |          |  |
| Maryland  |  |  | Anne Arundel  |  |  | Annapolis  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |   | 1055 Norman Dr, Apt. 111 |          |   |                |       |       |      |   |      |  |          |  |
| 14 FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| George  |  |  | Kiefer  |  |  | Mawley   |  |  |   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 12 INFORMANT   |  |  | ADDRESS   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| No  |  |  | 190 18 7620   |  |  | Joseph P. Connor   |  |  | See item 13   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage secondary to</u><br><u>Laennec's cirrhosis</u><br>5712<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |  |  |  |  |   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
|   |  |  |   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| 22a. I certify that (I (this hospital) attended the deceased from <u>April 26</u> , 19 <u>80</u> , to <u>May 11</u> , 19 <u>80</u> , that (I/(we) last saw the deceased alive on <u>May 11</u> , 19 <u>80</u> , and that in my/(our) opinion death occurred on the date and hour and from the causes stated above, (I/(we) (did) (did not) view the body after death.   |  |  |   |  |  |  |  |  |   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| 22b. SIGNATURE<br><u>Jeffrey M. Crane MD</u>  |  |  | DEGREE<br><u>MD</u>   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><u>May 12 1980</u>  |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Jeffrey M. Crane, M.D.</u>  |  |  | 22e. ADDRESS<br><u>National Naval Medical Center, Bethesda, Md.</u>                                       |  |  |  |  |  |   |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Cremation</u>   |  |  | 23b. DATE<br><u>13 May 1980</u>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Lincoln Cemetery</u>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Brentwood Pr. George Md.</u> |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>Jon M. Taylor &amp; Sons</u>  |  |  | ADDRESS<br><u>Annapolis, Maryland</u>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 15 1980</u>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                              |  |   |                          |          |   |                |       |       |      |   |      |  |          |  |

Original

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |   |  |   |  | REG. NO. 13225  |  |  |  |
|--|--|------------------|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>Alimamy S. Conteh   |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> May 11 19 80 |  | 2b. HOUR<br>2:35 P M                           |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>DAY MONTH YEAR<br>May 8, 1910   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>70 YRS.                                 |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS  |  | 7c. DATE PRONOUNCED DEAD<br>May 11, 19 80   |  | 7d. HOUR<br>2:35 P M                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Sierra Leone  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Sierra Leone  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD                          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Goldsmith  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Jewelry   |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2030 Georgian Woods Place                                      |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Yallah Conteh  |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jeneba Mansaray              |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>None  |  | 17. INFORMANT<br>ADDRESS<br>Betty Conteh, wife, same as above                 |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                  |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>None  |  |                  |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>None   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <u>John S. Rogers</u>   |  |                  |  |   |  | TITLE (SPECIFY)<br>M.D. <u>D.P.</u>   |  |   |  | DATE SIGNED <u>May 11, 1980</u>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>John S. Rogers, M.D.  |  |                  |  |   |  | ADDRESS<br>1919 Seminary Rd., Sil. Sprg., Md.                                 |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>May 14, 80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial Cem'ty.                |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, P. G., Md.                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>McGuire Funeral Service, Inc.  |  |                  |  |   |  | ADDRESS<br>7400 Georgia Ave NW, Wash DC                                       |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 13 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>History McCreedy |  |

1932 February 4, 11. 10. 1. 1. 1.

Central Bureau  
Service, Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

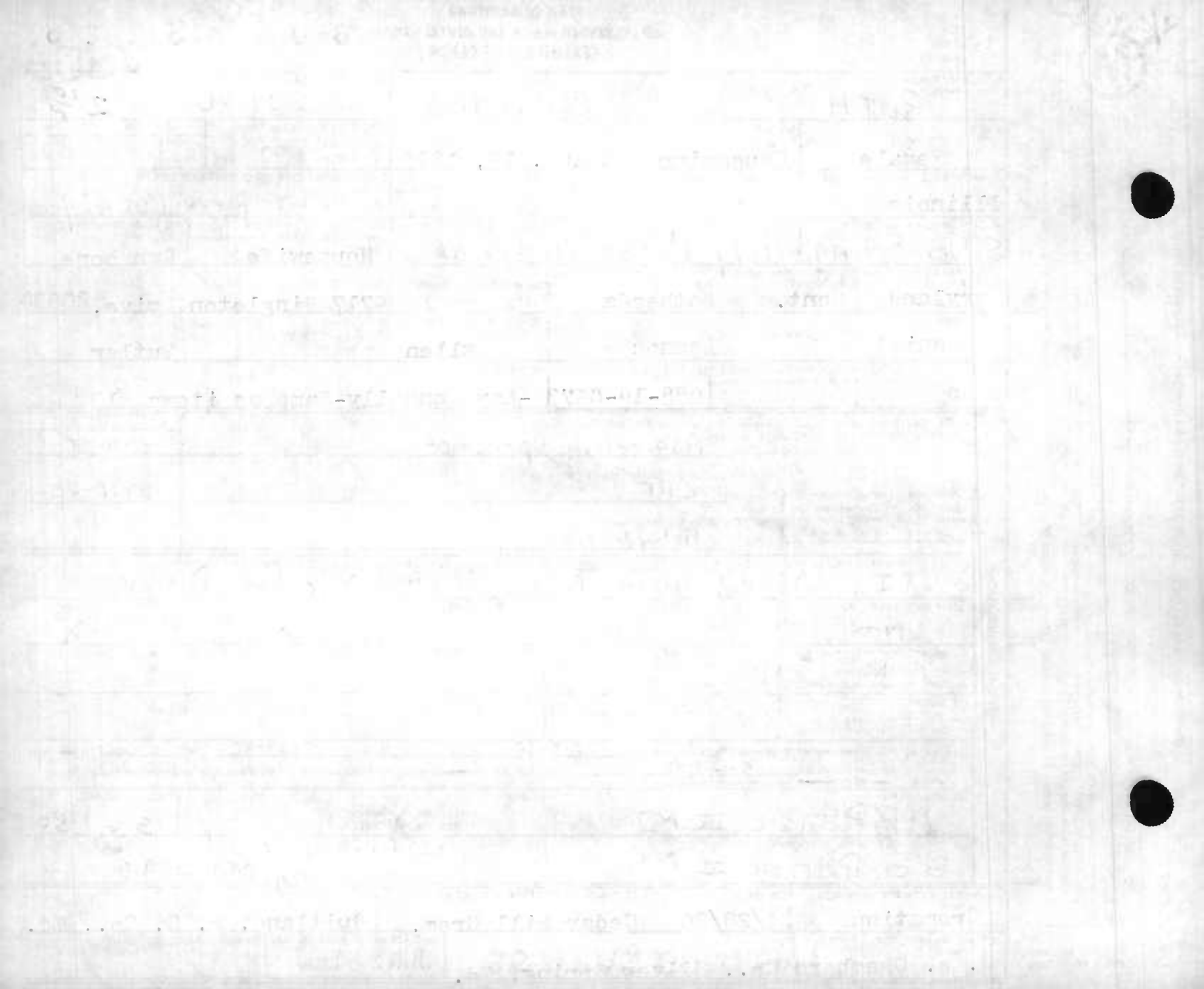
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

44

4503

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   |  |                            |  |  |
|--|--|--|--|--|--|---|--|--|---|--|----------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO. 8013226   |  |  |   |  |  |   |  |                            |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>RUTH</b>  |  |  | FIRST<br><b>CORVINUS</b>   |  |  | LAST<br><b>CORVINUS</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-27-80</b>  |  | 2b. HOUR<br><b>2:10 PM</b> |  |  |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>Caucasian</b>  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Aug. 19, 1889</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.   |  |                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>  |  |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |  |                            |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Mont.</b>  |  |  | 13c. CITY OR TOWN<br><b>Bethesda</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |                            | 13e. STREET ADDRESS<br><b>9717 Singleton Drive, 20034</b>          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Daniel Lennon</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ellen Butler</b>  |  |  |   |  |  |   |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO<br><b>262-80-8667</b>  |  |  | 17. INFORMANT ADDRESS<br><b>-Amy Donnelly-Same as items #13</b>   |  |  |   |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b><br><b>2765</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Dehydration</b> |  |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5-26-80</b><br><b>5-26-80</b> |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>UTI, ASCVD, Atherosclerotic Cerebral Vascular Disease</b>  |  |  |  |  |  |   |  |  |   |  |                            |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>NO</b>  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |                            |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |                            |  |  |
| 22a. I certify that (I) <del>viewed</del> attended the deceased from <b>5-27-80</b> , 19____, to <b>5-27-80</b> , 19____, that (I) <del>viewed</del> lost saw the deceased alive on <b>5-27-80</b> , 19____, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>viewed</del> (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |  |                            |  |  |
| 22b. SIGNATURE<br><b>G.B. Patrick III MD</b>   |  |  |  |  |  | DEGREE  |  |  |   | 22c. DATE SIGNED<br><b>5-27-80</b>   |                            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G.B. Patrick III MD</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>9221 Colesville Rd Silver Spring, Md 20910</b>   |  |  |   |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |  | 23b. DATE<br><b>5/28/80</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crem.</b>   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Suitland, P. G. Co., Md.</b>  |  |                            |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>W. W. Chambers Co., Silver Spring, Md.</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 2 1980</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |                            |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |   |  |  |  |   |
|---|--|---|--|---|---|---|--|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  |   |   |   |  |  |  |   |
| CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |  |   |
| REG. NO. 8 0 1 3 2 2 7  |  |   |  |   |   |   |  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Janet L. Cox.</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 7 1980</b>             |   |  |  |  | 2b. HOUR<br><b>8:10 p.m.</b>                    |
| 3. SEX<br><b>Female.</b>  |  | 4. RACE<br><b>White.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 19, 1937</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>43</b>                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>MD.</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Zealand.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery.</b>                      |  |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>1400 Fenwick Lane</b> |  |   |   | 12a. USUAL OCCUPATION<br><b>Artist Retired.</b>                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland.</b> 13b. COUNTY <b>Montgomery.</b> 13c. CITY OR TOWN <b>Silver Spring.</b> 13d. INSIDE CITY LIMITS? <input type="checkbox"/>   |  |   |  |   | 13e. STREET ADDRESS<br><b>1400 Fenwick Lane.</b>                  |   |  |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Lawrence</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Buchanan.</b> |   |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>168-30-4838</b>                                      |  | 17. INFORMANT<br>ADDRESS<br><b>Dr. James J. C. Cox 730 Timberland Dr. Berrien Spg. Mich.</b>  |   |   |  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>4149 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHD (coronary artery disease)</b> years<br>(c) <b>atherosclerosis</b> years. |  |   |  |   |   |   |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Aortic Stenosis</b>  |  |   |  |   |   |   |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-25</b> , 19 <b>79</b> , to <b>5-7</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>5-5</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                       |  |   |  |   |   |   |  |  |  |   |
| 22b. SIGNATURE<br><b>John L. Ford MD</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   | DATE SIGNED<br><b>5/8/80</b>  |  |  |  |   |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN L. FORD</b>  |  | 22d. ADDRESS<br><b>341 University City Silver Spring Md 20901</b>                   |  |   |   |   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation.</b>  |  | 23b. DATE<br><b>May 9 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bladensburg, D.C. Md. Geo.</b> |  |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. Arthur Walters.</b>   |  | ADDRESS<br><b>Takoma Funeral Home. 254 Carroll St. N. W.</b>                        |  | 25. DATE RECEIVED BY REGISTRAR<br><b>MAY 15 1980</b>  |   | 25. REGISTRAR'S SIGNATURE   |  |  |  |   |

RECEIVED  
MAY 19 1937  
U.S. DEPT. OF JUSTICE

|                   |     |       |
|-------------------|-----|-------|
| May 7 1937        | COX | James |
| May 14 1937       | COX | James |
| May 21 1937       | COX | James |
| May 28 1937       | COX | James |
| June 4 1937       | COX | James |
| June 11 1937      | COX | James |
| June 18 1937      | COX | James |
| June 25 1937      | COX | James |
| July 2 1937       | COX | James |
| July 9 1937       | COX | James |
| July 16 1937      | COX | James |
| July 23 1937      | COX | James |
| July 30 1937      | COX | James |
| August 6 1937     | COX | James |
| August 13 1937    | COX | James |
| August 20 1937    | COX | James |
| August 27 1937    | COX | James |
| September 3 1937  | COX | James |
| September 10 1937 | COX | James |
| September 17 1937 | COX | James |
| September 24 1937 | COX | James |
| October 1 1937    | COX | James |
| October 8 1937    | COX | James |
| October 15 1937   | COX | James |
| October 22 1937   | COX | James |
| October 29 1937   | COX | James |
| November 5 1937   | COX | James |
| November 12 1937  | COX | James |
| November 19 1937  | COX | James |
| November 26 1937  | COX | James |
| December 3 1937   | COX | James |
| December 10 1937  | COX | James |
| December 17 1937  | COX | James |
| December 24 1937  | COX | James |
| December 31 1937  | COX | James |

James Cox  
May 7 1937  
May 14 1937  
May 21 1937  
May 28 1937  
June 4 1937  
June 11 1937  
June 18 1937  
June 25 1937  
July 2 1937  
July 9 1937  
July 16 1937  
July 23 1937  
July 30 1937  
August 6 1937  
August 13 1937  
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September 3 1937  
September 10 1937  
September 17 1937  
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October 15 1937  
October 22 1937  
October 29 1937  
November 5 1937  
November 12 1937  
November 19 1937  
November 26 1937  
December 3 1937  
December 10 1937  
December 17 1937  
December 24 1937  
December 31 1937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |
| FIRST MIDDLE LAST   |  |   |  |   | MONTH DAY YEAR   |  |  | HOUR MIN.  |  |
| Zula Edna CRAWFORD  |  |   |  |   | May 12, 1980   |  |  | 1:30 P.M.  |  |
| 3 SEX   |  | 4 RACE  |  | 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                   |  | 7. IF UNDER 1 YEAR   |  |
| Female  |  | White   |  | MONTH DAY YEAR  |  | 89 YRS.  |  | IF UNDER 24 HRS.   |  |
| Feb. 4, 1891  |  |   |  |   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                              |  |  |  |
| Maryland  |  | U.S.A.  |  |   |  | Montgomery Co., MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |  |
| Gaithersburg  |  | Wilson Health Care Center   |  |   |  | Housewife  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN  |  |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 19100 Waring Station Rd.                                       |  |  |
| 14 FATHER'S NAME  |  |   |  |   | 15 MOTHER'S MAIDEN NAME  |  |  |  |  |
| FIRST MIDDLE LAST   |  |   |  |   | FIRST MIDDLE LAST  |  |  |  |  |
| Elmer Thomas  |  |   |  |   | Clellie Line   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO.   |  |   |  |   | 17 INFORMANT ADDRESS   |  |  |  |  |
| No 220-32-6616  |  |   |  |   | Marie Crawford Lowery, Seattle, Wash. 98166  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>atherosclerosis</u><br><u>4409</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>years</u> |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>congestive heart failure</u>   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 19c. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
|   |  |   |  |   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>3/27/80</u> 19 to <u>5/12/80</u> 19, that (1) (we) lost<br>saw the deceased alive on <u>5/12/80</u> 19, and that it (my/our) opinion death occurred on the date and hour and from the causes stated<br>above. (1) (we) did (did not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Cheryl Winchell</u> M.D.   |  |   |  |   | 22c. DATE SIGNED<br>May 12, 1980   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Cheryl Winchell, M.D.  |  |   |  |   | 22e. ADDRESS<br>19241 Montg. Village Avenue<br>Gaithersburg, Maryland                          |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                       |  |  |  |
| Burial  |  | May 15, 1980  |  | Neelsville  |  | Germantown, Montg., Md.  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME Olin L. Molesworth, Damascus, Md.   |  |   |  |   | 25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>MAY 15 1980 <u>Anthony McCreedy</u> |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

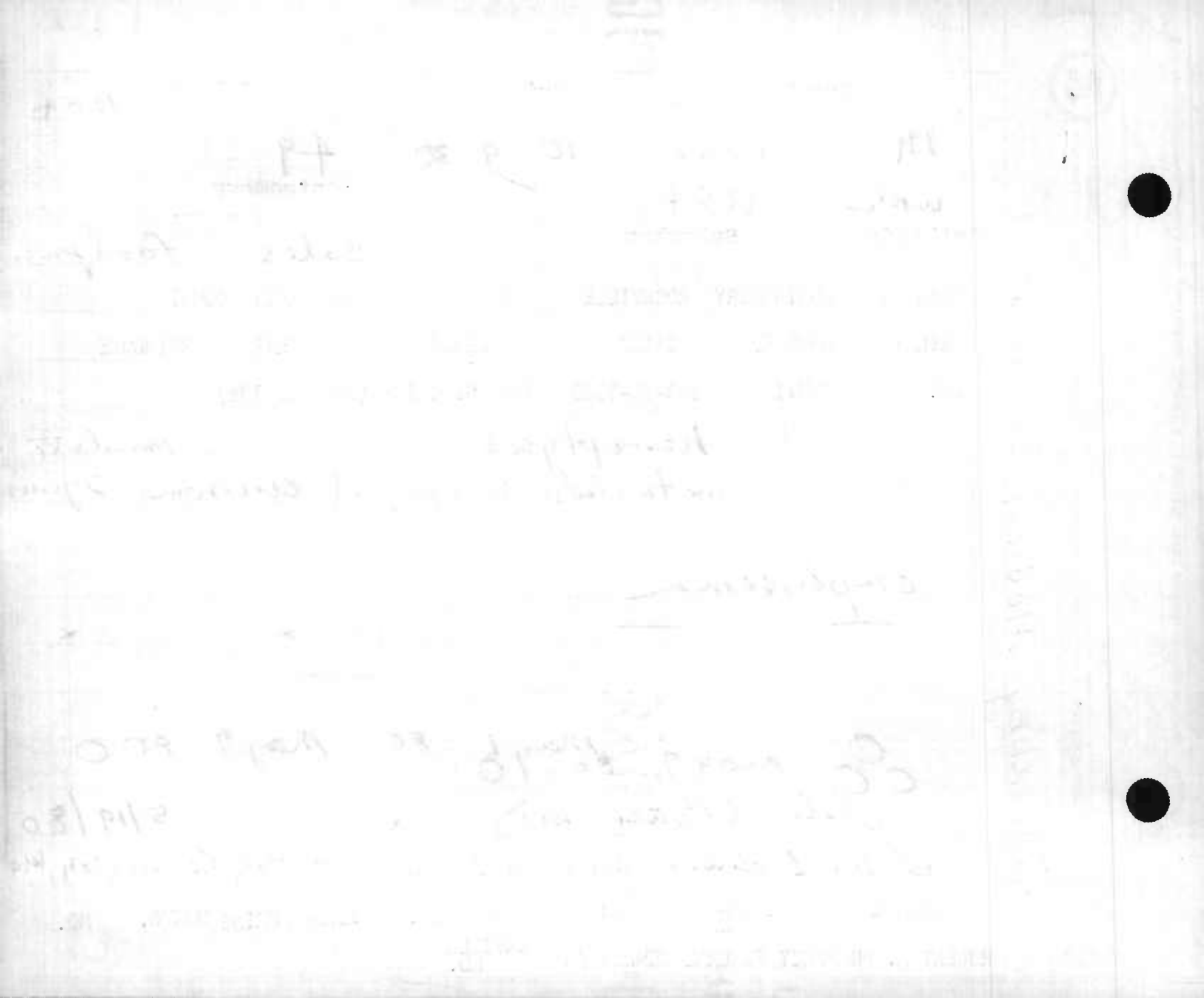
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Medical Examiner

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 0 1 3 2 2 9   |  |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>Frank L. Crisp  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 19 80   |  |
| 3. SEX<br>M  |  | 4. RACE<br>Cauc  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 9 30  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>49 YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>unk  |  | 8. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery   |  | 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS)<br>Suburban |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Food proc.  |  | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 13b. STREET ADDRESS<br>4808 ARCTIC COURT   |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br>RILEY MONROE CRISP  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>BESSIE CORDELIA RATHBONE  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>243-38-0563  |  | 17. INFORMANT ADDRESS<br>JOAN G. CRISP (SAME AS 13e)  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>hemoptysis</u><br>1619<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>metastatic laryngeal carcinoma 2 years</u><br>(c) <u>emphysema</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>emphysema</u> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u>  |  |
| 19a. DATE OF OPERATION<br><u>May 1 19 80</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>emphysema</u>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><u>---</u>   |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>---</u>   |  |
| 21f. LOCATION STREET<br><u>---</u>   |  | 21g. CITY OR TOWN<br><u>---</u>  |  | 21h. COUNTY<br><u>---</u>   |  |
| 21i. STATE<br><u>---</u>   |  | 22a. I certify that (I) (this hospital) attended the deceased from <u>May 1 19 80</u> to <u>May 9 19 80</u> , that (I) (we) lost spw the deceased alive on <u>May 9 19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>John L Barr, MD</u>  |  |
| 22c. DATE SIGNED<br><u>5/19/80</u>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>John L Barr, MD</u>  |  | 22e. ADDRESS<br><u>10500 Summit Ave, Kensington, MD</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>   |  | 23b. DATE<br><u>5-24-80</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>GATE OF HEAVEN CEM.</u>  |  |
| 23d. LOCATION CITY OR TOWN<br><u>SILVER SPRING MONTG.</u>  |  | 23e. COUNTY<br><u>MD.</u>  |  | 23f. STATE<br><u>MD.</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>ROBERT A. PUMPHREY FUNERAL HOMES P/A</u>  |  | 24a. CITY<br><u>ROCKVILLE</u>  |  | 24b. DATE REC'D. BY REGISTRAR<br><u>MAY 29 1980</u>   |  |
| 24c. REGISTRAR'S SIGNATURE<br><u>History/Rebudy</u>  |  | 24d. REGISTRAR'S NAME<br><u>---</u>  |  | 24e. REGISTRAR'S ADDRESS<br><u>---</u>  |  |





FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 1 3 2 3 0

|   |  |   |   |   |  |   |  |  |                                   |   |  |
|---|--|---|---|---|--|---|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SAMUEL L. CRIVELLA</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>6</b> YEAR <b>80</b> |   |  | 2b. HOUR<br><b>11 P</b> M   |  |  |                                   |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>MAY</b> DAY <b>20</b> YEAR <b>1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | # UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |                                   | # UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                   |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RESTAURANT OWNER</b>     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |   | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1908 STRATTON ROAD</b>   |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>NUNZIO</b> MIDDLE <b>CRIVELLA</b> LAST <b>CRIVELLA</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ROSARIO</b> MIDDLE <b>CITRANO</b> LAST <b>CITRANO</b>  |  |   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-32-5618</b>   |   | 17. INFORMANT<br><b>ROSELEA CRIVELLA</b>  |  |   |  | ADDRESS<br><b>SAME AS 13 WIFE</b>  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>congestive heart failure</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerotic Cardio Vasc. Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |   |  |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><b>carcinoma of the lung</b>   |  |   |   |   |  |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET<br><b>1969</b>  |  | CITY OR TOWN<br><b>5-6</b>  |  | COUNTY<br><b>80</b>  |                                   | STATE   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1969</b> 19 <b>5-6</b> to <b>5-6</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>5-6</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |   |   |  |   |  |  |                                   |   |  |
| 22b. SIGNATURE<br><b>Robert Kramer</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |   |  | 22c. DATE SIGNED<br><b>5/7/80</b>  |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT KRAMER</b>   |  |   |   | 22e. ADDRESS<br><b>8630 FENTON Street SILVER SPRING</b>   |  |   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>ENTOMBMENT</b>  |  | 23b. DATE<br><b>5/10/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FT. LINCOLN</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN<br><b>BRENTWOOD</b>  |                                   | COUNTY<br><b>PRI-GE0</b> STATE<br><b>MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b> ADDRESS<br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 9 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert Kramer</b>   |                                   |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

500 W. ST. LINDA, W. SILVER SPRING, MD. 20901  
FRANCIS J. COLLINS  
2/10/80 FT. LINCOLN

RESERVED FBI GEO

MC 820-22-7418 ROSIEA CRIVELLA SAME AS IS WIFE

MURKIN

CRIVELLA

CRIVELLA

CITIZEN

MARYLAND MONTGOMERY SILVER SPRING X 1902 STRATTON ROAD

SILVER SPRING

HOLY CROSS HOSPITAL

RESTAURANT OWNER

WIFE

WHITE

WOMEN 1904

MONTGOMERY

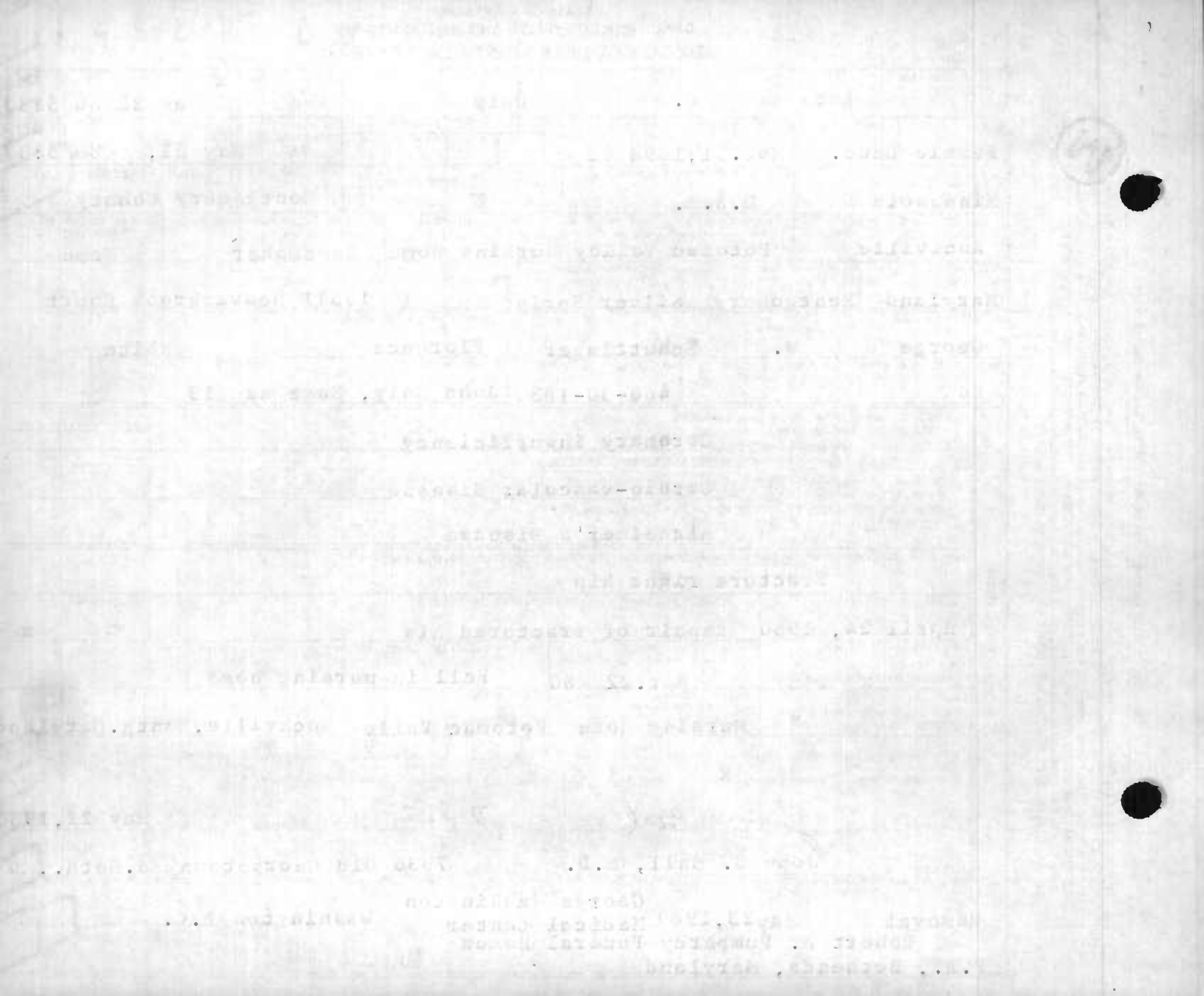
CITIZEN

CITIZEN

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR THE TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 15 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |  |  |  |   |  |  |  |                  | REG. NO. 13231  |  |
|--|----------------------|--|--|--|---|--|--|--|------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ruth M. Daly</b>  |                      |  |  |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>May 22, 1980</b> |  | 2b. HOUR <b>5:30</b>   |                  |   |  |
| 3. SEX <b>Female</b>   | 4. RACE <b>Cauc.</b> | 5. DATE OF BIRTH <b>Mar. 31, 1898</b>  | 6. AGE (IN YEARS) <b>82</b> YRS.   | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN.   | 2c. DATE PRONOUNCED DEAD <b>May 22, 1980</b>   |  | 2d. HOUR <b>5:30</b>   |                  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Minnesota</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>  |  |  |                  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Rockville</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac Valley Nursing Home</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>                                    |                  |   |  |
| 13a. STATE <b>Maryland</b>   |                      |  | 13b. COUNTY <b>Montgomery</b>  |  | 13c. CITY OR TOWN <b>Silver Spring</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |   |  |
| 14. FATHER'S NAME <b>George W. Schuttlinger</b>  |                      |  | 15. MOTHER'S MAIDEN NAME <b>Florence White</b>                                   |  |   | 13e. STREET ADDRESS <b>15311 Beaverbrook Court</b>   |  |  |                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                      |  | 16b. SOCIAL SECURITY NO. <b>468-30-1830</b>                                      |  | 17. INFORMANT ADDRESS <b>John Daly, Same as #13</b>   |  |  |  |                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardio-vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Alzheimer's Disease</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. |                      |  |  |  |   |  |  |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Fracture right hip</b>   |                      |  |  |  |   |  |  |  |                  |   |  |
| 19a. DATE OF OPERATION <b>April 24, 1980</b>   |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Repair of fractured hip</b> |  |   |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. Apr. 22 1980</b>            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell in nursing home</b> |  |  |  |                  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Nursing Home</b>  |  | 21f. LOCATION CITY OR TOWN <b>Potomac Valley</b> COUNTY <b>Rockville</b> STATE <b>Montg. Maryland</b>     |  |  |  |                  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                      |  |  |  |   |  |  |  |                  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>   |                      |  | TITLE (SPECIFY) <b>Deputy</b>  |  |   | DATE SIGNED <b>May 22, 1980</b>  |  |  | MEDICAL EXAMINER |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>  |                      |  | ADDRESS <b>7936 Old Georgetown Rd. Beth., MD</b>                                 |  |   |  |  |  |                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>   |                      |  | 23b. DATE <b>May 23, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Medical Center</b>                                |  |  | 23d. LOCATION CITY OR TOWN <b>Washington D.C.</b> COUNTY STATE                   |                  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>  |                      |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 27 1980</b>                                 |  |   | 25b. SIGNATURE <i>Robert A. Pumphrey</i>   |  |  |                  |   |  |
| <b>P.A., Bethesda, Maryland</b>  |                      |  |  |  |   |  |  |  |                  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

47  
71  
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1

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO.  |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Lois Laverne Daniel</b>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5 25 80</b>   |  |  |  | 2b. HOUR<br><b>3:25 AM</b>  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5/23/06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>54</b>   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br><b>54</b>  |  | 7. IF UNDER 24 HRS. HOURS MIN.<br><b>54</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>AMERICAN</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery, Md.</b>                             |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House Wife</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  |   |  | 13b. COUNTY<br><b>P. Geo.</b>  |  | 13c. CITY OR TOWN<br><b>Adelphi</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Wendall Young</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Evelyn Beck</b>  |  |  |  | 16. STREET ADDRESS<br><b>2009 Erie St. Adelphi, Md.</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No.</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>578-26-5372</b>   |  | 17. INFORMANT<br><b>Charles E. Daniel. (13 e)</b>   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>TERMINAL CANCER COLON</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTASIS to LIVER AL. adenoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPOENSION</b>                                 |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>— P.M. — 19 —</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b> |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>— — — — —</b>                         |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/23/80</b> to <b>5/25/80</b> , that (I) (we) last saw the deceased alive on <b>5/23/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Tony P. Kannarkat</b>   |  |  |  |   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/25/1980</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TONY P. KANNARKAT</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>8201 16th St<br/>SILVER SPRING MD 20910</b>                             |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>May 28, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn</b>                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Rockville, Montg. Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Takoma Funeral Home</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

Washington, D. C.

Telephone: 222-1234

2000 12th St. N.W.

Mr. J. Edgar Hoover

Room

100

Young

Room

712-26-2272 (Ext. 111)

No.

NOV 10 1964



Washington, D. C.

Room 100

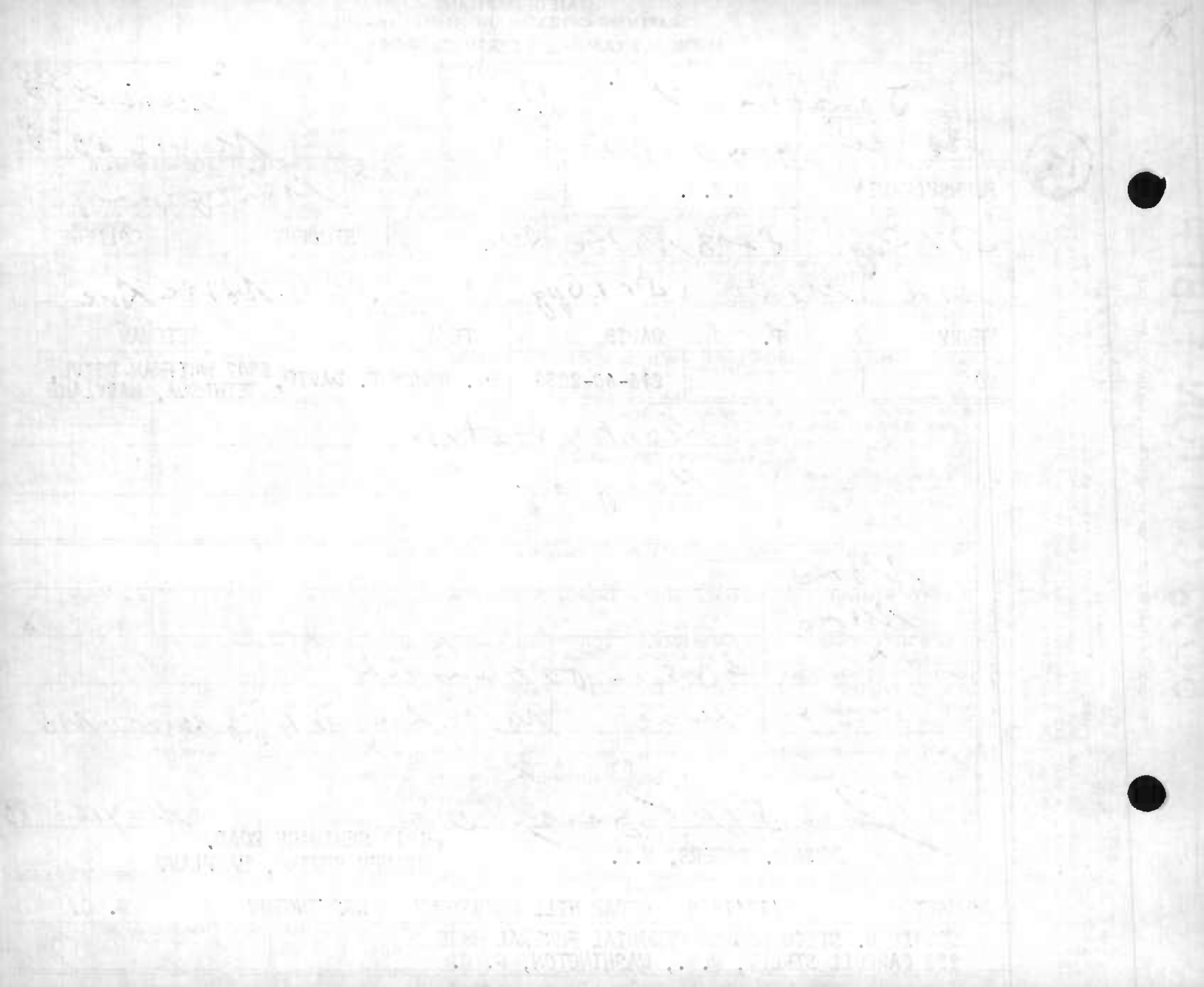
Room

712-26-2272 (Ext. 111)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 13233   |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | 20. DATE KNOWN OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>JONATHAN V. DAVID</b>   |  |  |  |  |  |  |  |  |  | 21. DATE ESTIMATED <b>May 12 1980</b>  |  |
| 2. SEX <b>MALE</b>  |  |  |  |  |  |  |  |  |  | 22. DATE PRONOUNCED DEAD <b>May 12 1980</b>  |  |
| 3. RACE <b>WHITE</b>  |  |  |  |  |  |  |  |  |  | 23. HOUR <b>3:30 PM</b>  |  |
| 4. DATE OF BIRTH <b>May 2 1925</b>  |  |  |  |  |  |  |  |  |  | 24. HOUR <b>3:30 PM</b>  |  |
| 5. AGE (IN YEARS) <b>55</b>   |  |  |  |  |  |  |  |  |  | 25. MONTHS <b>25</b>   |  |
| 6. IF UNDER 1 YR. MONTHS <b>25</b> DAYS <b>25</b> HOURS <b>25</b> MIN. <b>25</b>  |  |  |  |  |  |  |  |  |  | 26. IF UNDER 24 HRS. MONTHS <b>25</b> DAYS <b>25</b> HOURS <b>25</b> MIN. <b>25</b>  |  |
| 7a. BIRTHPLACE (STATE OR COUNTY) <b>PENNSYLVANIA</b>  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Sil Spg</b>  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>#208 Nolte Ave</b>      |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STUDENT</b>  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>COLLEGE</b>   |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Mont</b> 13c. CITY OR TOWN <b>BETHESDA</b>  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME (TYPE OR PRINT) <b>HENRY P. DAVID</b>   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>TEMA SEIDMAN</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>216-60-2236</b>  |  |
| 17. INFORMANT (TYPE OR PRINT) <b>DR. HENRY P. DAVID</b>   |  |  |  |  |  |  |  |  |  | 17. ADDRESS <b>8307 WHITMAN DRIVE, BETHESDA, MARYLAND</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxiation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>9530</b><br>(b) <b>Hanging</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>None</b>  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:00 P.M. 5 12 1980</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Hung off</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>  |  |
| 21f. LOCATION (CITY OR TOWN, STREET, CITY OR TOWN, COUNTY, STATE) <b>Nolte Ave, Sil Spg, Mont MD</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b> M.D. <b>DRP</b>  |  |  |  |  |  |  |  |  |  | TITLE (SPECIFY) <b>1919 SEMINARY ROAD, SILVER SPRING, MARYLAND</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS, M.D.</b>   |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>May 12 1980</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>CREMATION</b>  |  |  |  |  |  |  |  |  |  | 23b. DATE <b>5/13/1980</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (CITY OR TOWN, STREET, CITY OR TOWN, COUNTY, STATE) <b>WASHINGTON D.C.</b>   |  |
| 24. FUNERAL DIRECTOR (TYPE OR PRINT) <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>  |  |  |  |  |  |  |  |  |  | DATE REC'D BY REGISTRAR <b>MAY 16 1980</b>   |  |
| 25. REGISTRAR'S SIGNATURE <b>Anthony J. Brady</b>   |  |  |  |  |  |  |  |  |  |  |  |





## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |  |  |   |   |  |  |                  |  |
|--|--|---|---|--|--|---|---|--|--|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Dorothy R. Davis</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/20/80</b>                 |  |  | 2b. HOUR<br><b>3:40 AM</b>  |   |  |  |                  |  |
| 3 SEX<br><b>Female.</b>  |  | 4 RACE<br><b>White.</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 25, 1914</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |                  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alleghany Co., N.C.</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery.</b> MD.                                       |   |  |  |                  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Takoma Park.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HOSPITAL, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp.</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired U.S. Post Office.</b> |   | 12b KIND OF BUSINESS OR INDUSTRY   |  |                  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland.</b>   |  |   |   |  | 13b COUNTY<br><b>Montgomery.</b>   |   | 13c CITY OR TOWN<br><b>Takoma Park.</b> |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elbert E vans.</b>   |  |   |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura Evans.</b>                    |   |   |  |  |                  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>  |  |   | 16b SOCIAL SECURITY NO.<br><b>239-20-2648</b>                         |  | 17 INFORMANT<br>ADDRESS<br><b>Kenneth Florence. 4990 Columbia Pike. Arlington, Va.</b> |   |   |  |  |                  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cerebro Vascular accident</b><br><b>496-</b> DUE TO, OR AS A CONSEQUENCE OF.<br>(b) <b>Chronic Obstructive Pulmonary disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>Coronary artery disease</b> |  |   |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |   |   |  |  |                  |  |
| 19a DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |                  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                      |   |  |  |                  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1970</b> , 19____, to <b>5-20</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>5-20</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |   |   |  |  |                  |  |
| 22b. SIGNATURE<br><b>Margaret T Snow</b>   |  |   |   |  |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |   |  |  | 22e ADDRESS   |   |  |  |                  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial.</b>   |  |   | 23b DATE<br><b>May 23, 1980</b>                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill.</b>                               |   |   | 23d. LOCATION<br>CITY COUNTY STATE<br><b>Suitland Rd. P. G. Co.</b>  |  |                  |  |
| 24 FUNERAL DIRECTOR<br>Name<br><b>John F. Waters 164 Carroll St. NW.</b>   |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR<br><b>MAY 26 1980</b>   |  |                  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

14

Female.

White.

Age 17, 1924

72

London Ave.

+

Alfredson Co., Inc.

Thomas Park, Washington

Revised U.S. Post Office

Flower Ave, Thomas Park

Marjorie Montgomery, Thomas Park

White

Young

Female

Young

Arlington, Va.

222-20-2241 Mont. St. Florence, 4800 Columbia Pike

9

10

200-10000

Female

Age 17, 1924

London Ave.

Revised U.S. Post Office

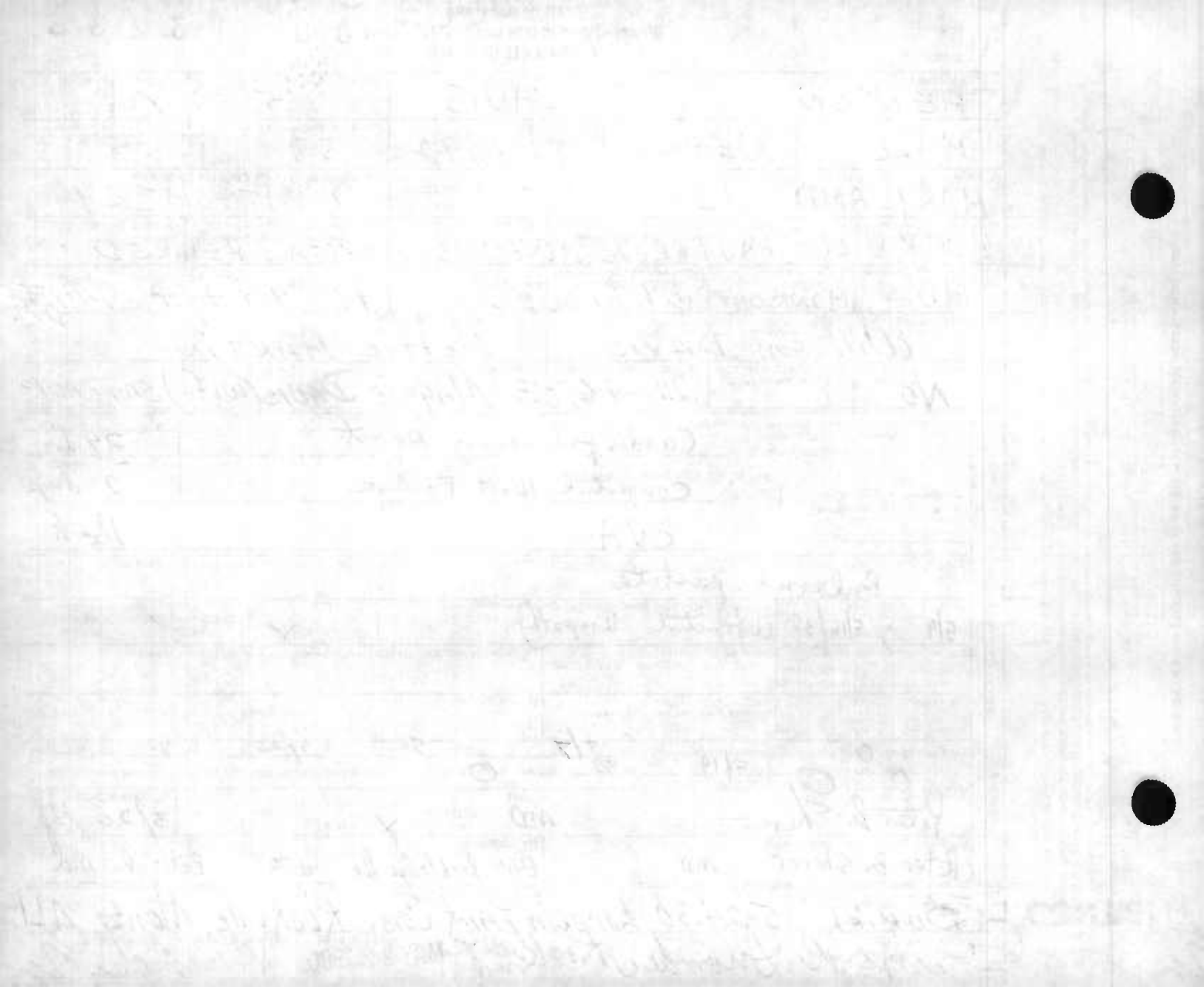
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

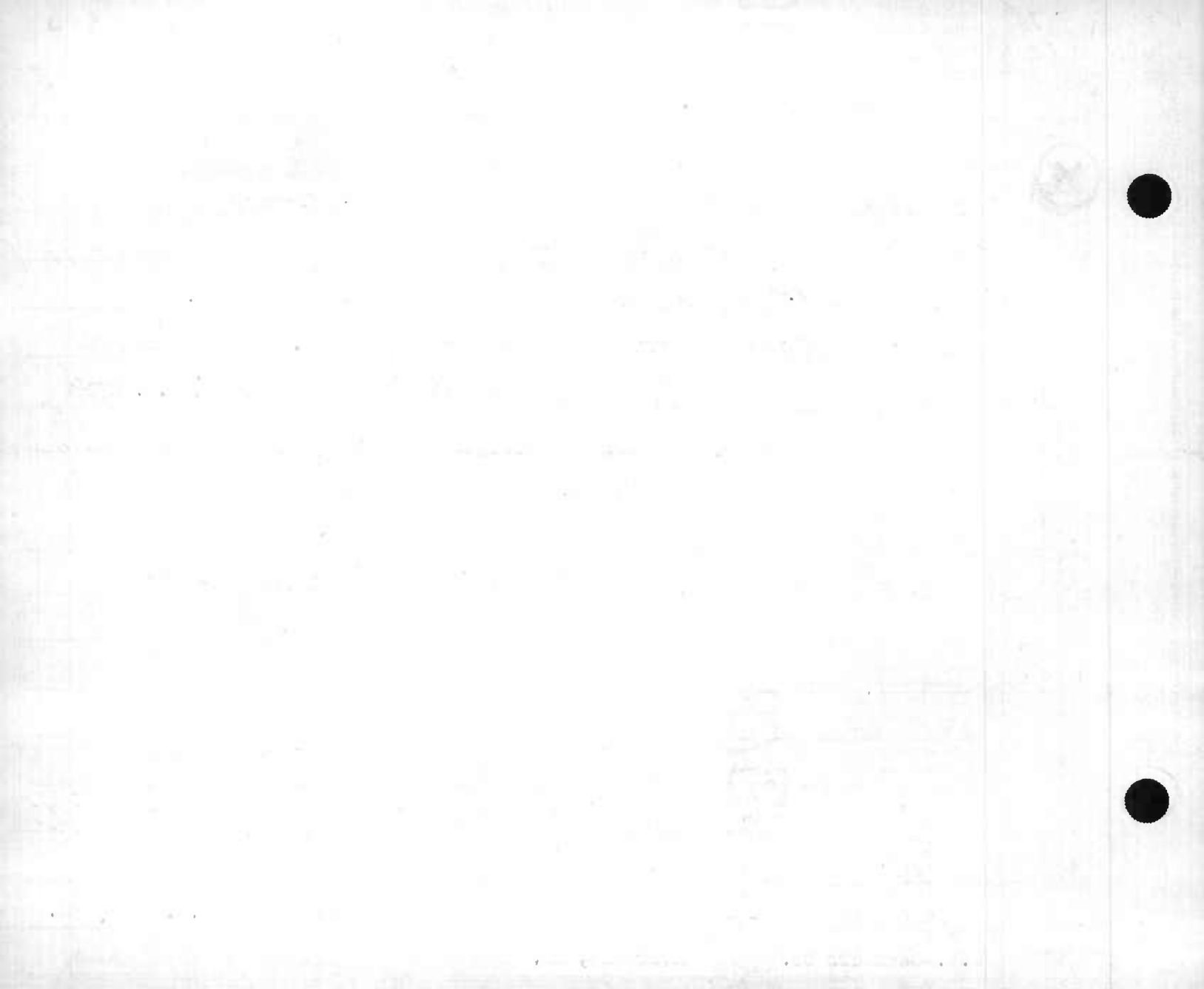
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 0 1 3 2 3 5  |  |
|--|--|--|--|--|--|
| FOR<br>STATE<br>REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |
| HENSON   |  |  |  | 5/20/80  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |
| MALE   |  | NEGRO  |  | 9/18/92  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| MARYLAND   |  | U.S.   |  | 87   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| ROCKVILLE  |  | SHADY GROVE ADVENTIST HOSPITAL   |  | MONTGOMERY   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| MO.  |  | MONTGOMERY   |  | Tobytown Lane  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| William DAVIS  |  | Nettie MARTIN  |  | RETIRED  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  |
| NO   |  | 216-146753   |  | Maggie DAVIS (Wife) same as 13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |
| IMMEDIATE CAUSE (a) 436- Cardiac pulmonary arrest  |  |  |  | 29 hr  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure  |  |  |  | 2 days   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) CVA   |  |  |  | 1 1/2 wk   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| Enlarged prostate  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
| 5/9 ; 5/16/80  |  | obstructive uropathy   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|  |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 5/9 19 80, to 5/20 19 80, that (we) last saw the deceased alive on 5/19 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Peter B. Sherer  |  | MD   |  | 5/20/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. REGISTRAR'S SIGNATURE   |  |
| Peter B. Sherer MD   |  | 6410 Rockledge Dr. #308 Bethesda Md  |  | Rocky McHenry  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | 5-24-80  |  | Lincoln Park Cem   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. DATE REC'D. BY REGISTRAR  |  | 25. REGISTRAR'S SIGNATURE  |  |
| Roger R. Snowden   |  | MAY 22 1980  |  | Rocky McHenry  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |   |  |  |  |   | 8   | 0 | 1  | 3  | 2   | 3 | 6 |
|---|--|--|--|--|---|--|--|--|---|---|---|--|--|---|---|---|
| 1. FOR STATE REGISTRAR  |  |  |  |  |   |  |  |  |   | REG. NO.  |   |  |  |   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT) <b>John H. DAVIS</b>   |  |  |  |  |   |  |  |  |   | 2a. DATE OF DEATH MONTH <b>5</b> DAY <b>6</b> YEAR <b>1980</b>                  |   |  | 2b. HOUR <b>4</b> P.M.                               |   |   |   |
| 3. SEX <b>MALE</b>  |  |  | 4. RACE <b>WHITE</b>   |  |   | 5. DATE OF BIRTH MONTH <b>3</b> DAY <b>16</b> YEAR <b>1904</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.  |   |   | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.  |   |   |  |  |   |   |   |
| 10. CITY OR TOWN OF DEATH <b>TAKOMA PARK, MD</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SLIGO GARDENS NURSING HOME</b> |  |   |  |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LITHOGRAPH</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>LITHOGRAPHY</b> |   |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |   |  |  |  |   |   |   |  |  |   |   |   |
| 13a. STATE <b>MD</b>  |  |  | 13b. COUNTY <b>Montgom.</b>  |  |   | 13c. CITY OR TOWN <b>TAKOMA PK</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |   | 13e. STREET ADDRESS <b>7051 Carroll Ave.</b> |  |   |   |   |
| 14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Joshua</b> LAST <b>Davis</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Harriett</b> MIDDLE <b>C.</b> LAST <b>Padgett</b> |  |  |  |   |   |   |  |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  |  |  | 16b. SOCIAL SECURITY NO <b>578-01-4304</b>  |  |  |  |   | 17. INFORMANT ADDRESS <b>95 Abbotsford Rd. North Plainfield, N.J. 07062</b>     |   |  |  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4140 ACUTE CARDIAC ARREST</b>   |  |  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN.</b>                     |   |  |  |   |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY HEART DISEASE</b>   |  |  |  |  |   |  |  |  |   | <b>5 YRS.</b>   |   |  |  |   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>RECENT CEREBRAL THROMBOSIS &amp; RIGHT HEMIPLEGIA</b>   |  |  |  |  |   |  |  |  |   |   |   |  |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>RECENT CEREBRAL THROMBOSIS &amp; RIGHT HEMIPLEGIA</b>  |  |  |  |  |   |  |  |  |   |   |   |  |  |   |   |   |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |  |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>19</b> DAY <b>19</b> YEAR <b>1980</b>  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |   |   |  |  |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f. LOCATION STREET <b>CONNECTICUT AVE. N.W.</b>  |  |  | 21g. CITY OR TOWN <b>SUITLAND</b> COUNTY <b>P.G.</b> STATE <b>Md.</b>   |   |   |  |  |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1957</b> , 19____, to <b>MAY 6</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>MAY 6</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |  |   |   |   |  |  |   |   |   |
| 22b. SIGNATURE <b>Saul Zuckerman MD</b> DEGREE <b>MD</b>  |  |  |  |  |   |  |  |  |   | 22c. DATE SIGNED <b>5-6-80</b>  |   |  |  |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAUL ZUCKERMAN, M.D.</b>   |  |  |  |  |   |  |  |  |   | 22e. ADDRESS <b>5410 CONNECTICUT AVE. N.W.</b>                                  |   |  |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  |  | 23b. DATE <b>5-7-80</b>  |  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>   |  |  | 23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>P.G.</b> STATE <b>Md.</b>  |   |   |  |  |   |   |   |
| 24. FUNERAL DIRECTOR NAME <b>W.W. Chambers Co.</b> ADDRESS <b>Riversdale, Md.</b>   |  |  |  |  |   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAY 16 1980</b>                                |   |  | 25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>  |   |   |   |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |   |   |   |   |   |  |
|--|--|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARDLOD S. DAY</b>  |  |   | 2a. DATE OF DEATH MONTH <b>5</b> DAY <b>5</b> YEAR <b>80</b>                           |   |   | 2b. HOUR <b>109</b> M   |   |   |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>MAY</b> DAY <b>18</b> YEAR <b>1924</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.                                    |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>IOWA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.                        |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>WHEATON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10907 AMHERST AVENUE</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DISTRIBUTOR</b>                         |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>WASH. POST</b>                           |   |  |
| 13a. STATE <b>MARYLAND</b>   |  |   | 13b. COUNTY <b>MONTGOMERY</b>  |   | 13c. CITY OR TOWN <b>WHEATON</b>  |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>STEPHEN</b> MIDDLE <b>J.</b> LAST <b>DAY</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>DELLA</b> MIDDLE <b>GARVEN</b> LAST <b>GARVEN</b> |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>  |  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES) <b>WW II</b>                    |   | 17. INFORMANT <b>MILDRED B. DAY</b>   |   |   | ADDRESS <b>SAME AS 13 WIFE</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BRONCHIOGENIC CARCINOMA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(d) _____ |  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mos.</b><br><b>1 yr.</b> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</b>   |  |   |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                       |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                              |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |
| 22a. I certify that (i) (this hospital) attended the deceased from <b>4/28</b> 19 <b>80</b> to <b>5/5</b> 19 <b>80</b> , that (ii) (we) last saw the deceased alive on <b>4/28</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |   |   |  |
| 22b. SIGNATURE <b>James R. Coleman M.D.</b>  |  |   |  |   | DEGREE  |   | 22c. DATE SIGNED <b>5-5-80</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES R. COLEMAN</b>  |  |   |  |   | 22e. ADDRESS <b>2244 COLUMBIA BLVD SILVER SPRING, MD. 20910</b>   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |   | 23b. DATE <b>5/8/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>ROCKVILLE MONT MD.</b>          |   |  |
| 24. FUNERAL DIRECTOR <b>FRANCIS J. COLLINS</b><br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAY 9 1980</b><br>25b. REGISTRAR'S SIGNATURE <b>Jeffrey K. [Signature]</b> |   |   |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

|            |          |          |               |         |       |       |
|------------|----------|----------|---------------|---------|-------|-------|
| NAME       | DATE     | INITIALS | ADDRESS       | CITY    | STATE | ZIP   |
| STEPHEN J. | 11-11-61 | DAV      | 10907 WHEATON | WHEATON | MD    | 20897 |
| DAVID      | 11-11-61 | DAV      | 10907 WHEATON | WHEATON | MD    | 20897 |
| DAVID      | 11-11-61 | DAV      | 10907 WHEATON | WHEATON | MD    | 20897 |
| DAVID      | 11-11-61 | DAV      | 10907 WHEATON | WHEATON | MD    | 20897 |
| DAVID      | 11-11-61 | DAV      | 10907 WHEATON | WHEATON | MD    | 20897 |
| DAVID      | 11-11-61 | DAV      | 10907 WHEATON | WHEATON | MD    | 20897 |
| DAVID      | 11-11-61 | DAV      | 10907 WHEATON | WHEATON | MD    | 20897 |
| DAVID      | 11-11-61 | DAV      | 10907 WHEATON | WHEATON | MD    | 20897 |
| DAVID      | 11-11-61 | DAV      | 10907 WHEATON | WHEATON | MD    | 20897 |
| DAVID      | 11-11-61 | DAV      | 10907 WHEATON | WHEATON | MD    | 20897 |

10907 WHEATON  
 WHEATON, MD 20897  
 11-11-61  
 DAV

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

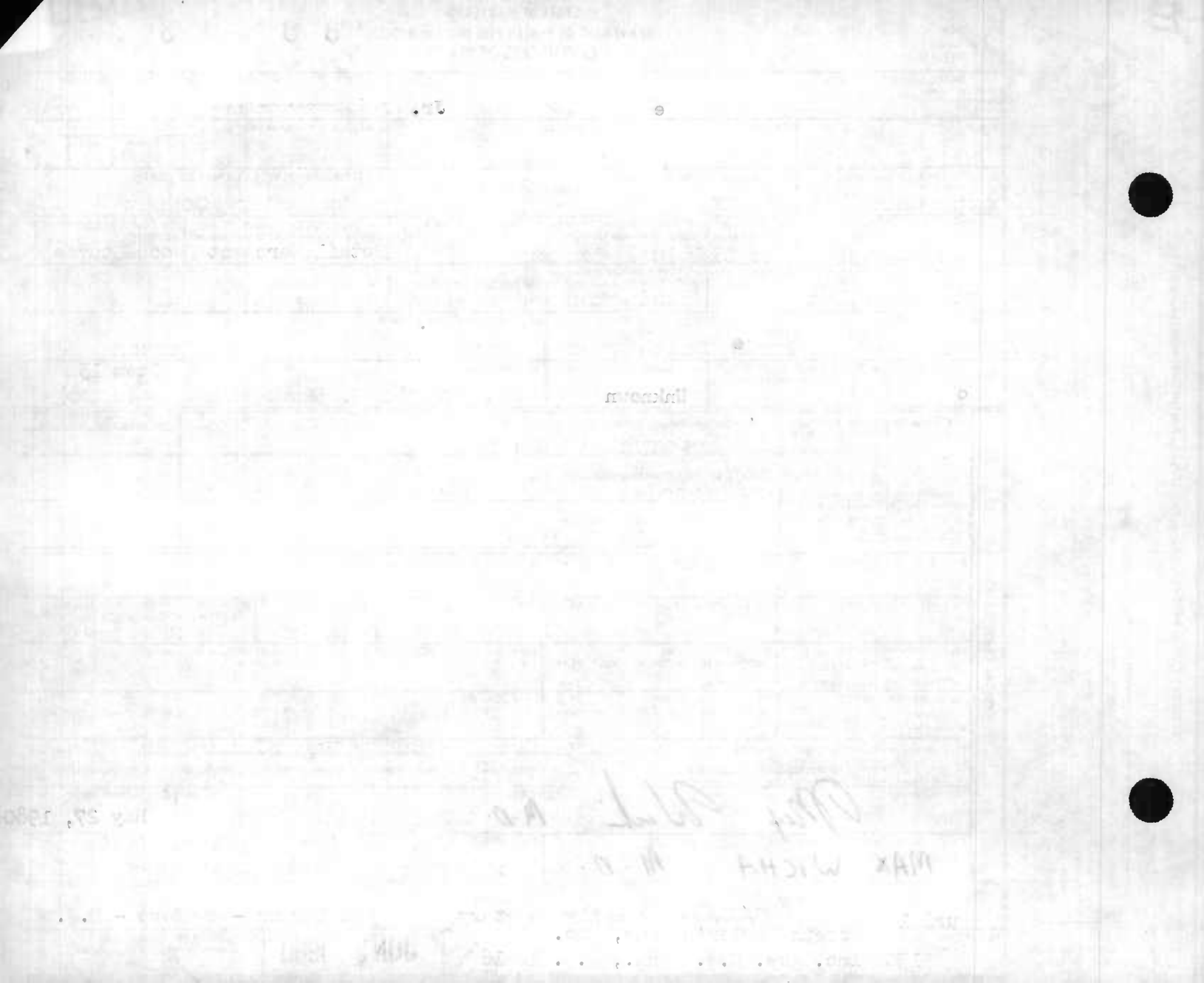
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 1 3 2 3 8  |  |   |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a DATE OF DEATH   |  |   |  | 2b HOUR   |  |   |  |
| FIRST MIDDLE LAST<br>Robert Earle Deatherage Jr.   |  |   |  | MONTH DAY YEAR<br>May 27, 1980   |  |   |  | 8:25aM  |  |   |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 7 UNDER 1 YEAR  |  | 7 UNDER 24 HRS  |  |
| Male   |  | White   |  | MONTH DAY YEAR<br>September 17, 1953   |  | 26 YRS  |  | MONTHS DAYS   |  | HOURS MIN   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |  |
| North Carolina   |  | USA   |  | Montgomery County MD   |  |   |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |   |  |
| Bethesda   |  | The Clinical Center, NIH  |  |  |  | Retail Merchant   |  | Food Stores   |  |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13b INSIDE CITY LIMITS?  |  | 13c STREET ADDRESS  |  |   |  |   |  |
| North Carolina   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 24 2nd St. Drive  |  |   |  |   |  |
| 14 FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |   |  |
| FIRST MIDDLE LAST<br>Robert Earle Deatherage   |  |   |  | FIRST MIDDLE LAST<br>Susan Sanderson   |  |   |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b SOCIAL SECURITY NO   |  | 17 INFORMANT  |  |   |  | ADDRESS   |  |
| No   |  |   |  | Unknown  |  | Mrs. Laurie G. Deatherage   |  |   |  | Item 13<br>(same)   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hemorrhagic shock</u><br>2028<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diffuse undifferentiated lymphoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hepatic failure</u>   |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |   |  |   |  |
| 19a DATE OF OPERATION  |  |   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY?  |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?    |  |
|  |  |   |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
|  |  |   |  |  |  |   |  |   |  |   |  |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 15, 19 80</u> , to <u>May 27, 19 80</u> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased <u>above</u> <u>May 27, 19 80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) did not view the body after death |  |   |  |  |  |   |  |   |  |   |  |
| 22b SIGNATURE  |  |   |  | DEGREE   |  |   |  | 22c DATE SIGNED   |  |   |  |
| <u>Max Wicha</u>   |  |   |  | M.D.   |  |   |  | May 27, 1980  |  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e ADDRESS  |  |   |  |   |  |   |  |
| MAX WICHA  |  |   |  | The Clinical Center, National<br>Institutes of Health, Bethesda, Md 20205  |  |   |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                           |  |   |  |
| Burial   |  |   |  | 5/30/80  |  | Family Cemetery   |  | Washington -Beaufort - N.C.   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  | 25a DATE REC'D. BY REGISTRAR   |  |   |  | 25b REGISTRAR'S SIGNATURE   |  |   |  |
| Joseph Gawler's Sons, Inc.<br>5130 Wisc. Ave. N.W. Wash., D.C. 20016   |  |   |  | JUN 3 1980   |  |   |  | <u>Max Wicha</u>  |  |   |  |



1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

1-800-368-1234

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 2 3 9<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   |  |
|--|--|--|--|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | REG. NO.   |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Albert Del Signore</b>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-4-80</b>                                 |   |  | 2b. HOUR<br><b>4:40 A M</b>                                      |   |  |
| 3 SEX<br><b>M</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5-30-14</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>65 years</b>                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>15 4 4 40</b> |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY County MD.</b>             |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                    |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  |  | 13b. COUNTY<br><b>Montgomery</b>   |   | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |  | 13d. STREET ADDRESS<br><b>10306 Crestmoor Drive</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sante Del Signore</b>  |  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucy Centofanti</b>               |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-18-2976</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>Hazel B. Del Signore (wife) Silver Spring, Md.</b>   |  |   |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY FAILURE</b><br><b>496 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-</b><br>Approximate interval between onset and death<br><b>2 WEEKS</b><br><b>10 YEARS</b> |  |  |  |  |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>KYPHOSCOLIOSIS, EMPHYSEMA</b>  |  |  |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>March 19 75</b> to <b>5/4 19 80</b> , that (1) we last saw the deceased alive on <b>5/4 19 80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (we did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Martin C. Shargel M.D.</b>  |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>5/4/80</b>                                |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN C. SHARGEL, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>3720 FARRAGUT AVE.<br/>KENSINGTON MD-20795</b>  |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/7/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>S.S. Montgomery Md.</b>        |  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Hines/Rinaldi Funeral Home</b>   |  | ADDRESS<br><b>Silver Spring, Md.</b>   |  | DATE REC'D. BY REGISTRAR<br><b>MAY 7 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                |  |  |   |  |

IN SENATE  
January 20, 1914  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 14, 1913

ALBANY:  
JANUARY 20, 1914  
PRINTED BY THE  
UNIVERSITY OF THE STATE OF NEW YORK  
AT ALBANY

ALBANY:  
JANUARY 20, 1914  
PRINTED BY THE  
UNIVERSITY OF THE STATE OF NEW YORK  
AT ALBANY

ALBANY:  
JANUARY 20, 1914  
PRINTED BY THE  
UNIVERSITY OF THE STATE OF NEW YORK  
AT ALBANY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 2 4 0  
CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a DATE OF DEATH MONTH DAY YEAR  |  |
| VINCENT THEODORE DeVITA III   |  | MAY 27, 1980   |  |
| 3 SEX   | 4 RACE   | 5 DATE OF BIRTH MONTH DAY YEAR   | 6 AGE (IN YEARS LAST BIRTHDAY)   |
| MALE  | WHITE  | OCTOBER 2, 1962  | 17   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH  |
| D.C.  | U.S.A.   |  | MONTGOMERY COUNTY, MD.   |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b KIND OF BUSINESS OR INDUSTRY   |
| BETHESDA  | CLINICAL CENTER (NIH)  | STUDENT  | HIGH SCHOOL  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a INSIDE CITY LIMITS?  | 13b STREET ADDRESS   |
| 13a STATE   | 13b COUNTY   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | JULLIARD DR. 20034   |
| MARYLAND  | Montgomery   |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  | 16 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |
| VINCENT T DeVITA, JR.   | MARY K. BUSH   | NO   |  |
| 17b SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS   |  |
| NONE  |  | MR. VINCENT DeVITA (FATHER) SAME AS AB   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) APLASTIC ANEMIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CARDIOMYOPATHY AND IRON OVERLOAD                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 YRS  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |
| 19a DATE OF OPERATION   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (X) this hospital attended the deceased from SEPTEMBER 15, 1972, to MAY 27, 1980, that X (we) last saw the deceased alive on MAY 27, 1980, and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (do not) view the body after death. |  |  |  |
| 22b SIGNATURE<br>Robert Maguire   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED<br>5/27/80   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT MAGUIRE  | 22e ADDRESS<br>NATIONAL INSTITUTES OF HEALTH<br>CLINICAL CENTER, BETHESDA, MD. 20205   |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   | 23b DATE   | 23c NAME OF CEMETERY OR CREMATORY  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE  |
| Burial  | May 30, 1980   | Parklawn Cemetery  | Rockville, Montgomery, Md.   |
| 24 FUNERAL DIRECTOR<br>Joseph Gawler's Sons, Inc.<br>5130 Wisconsin Ave., N. W., Wash., D. C. 20016   |  | 25a DATE REC'D. BY REGISTRAR<br>JUN 3 1980   | 25b REGISTRAR'S SIGNATURE<br>[Signature]   |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

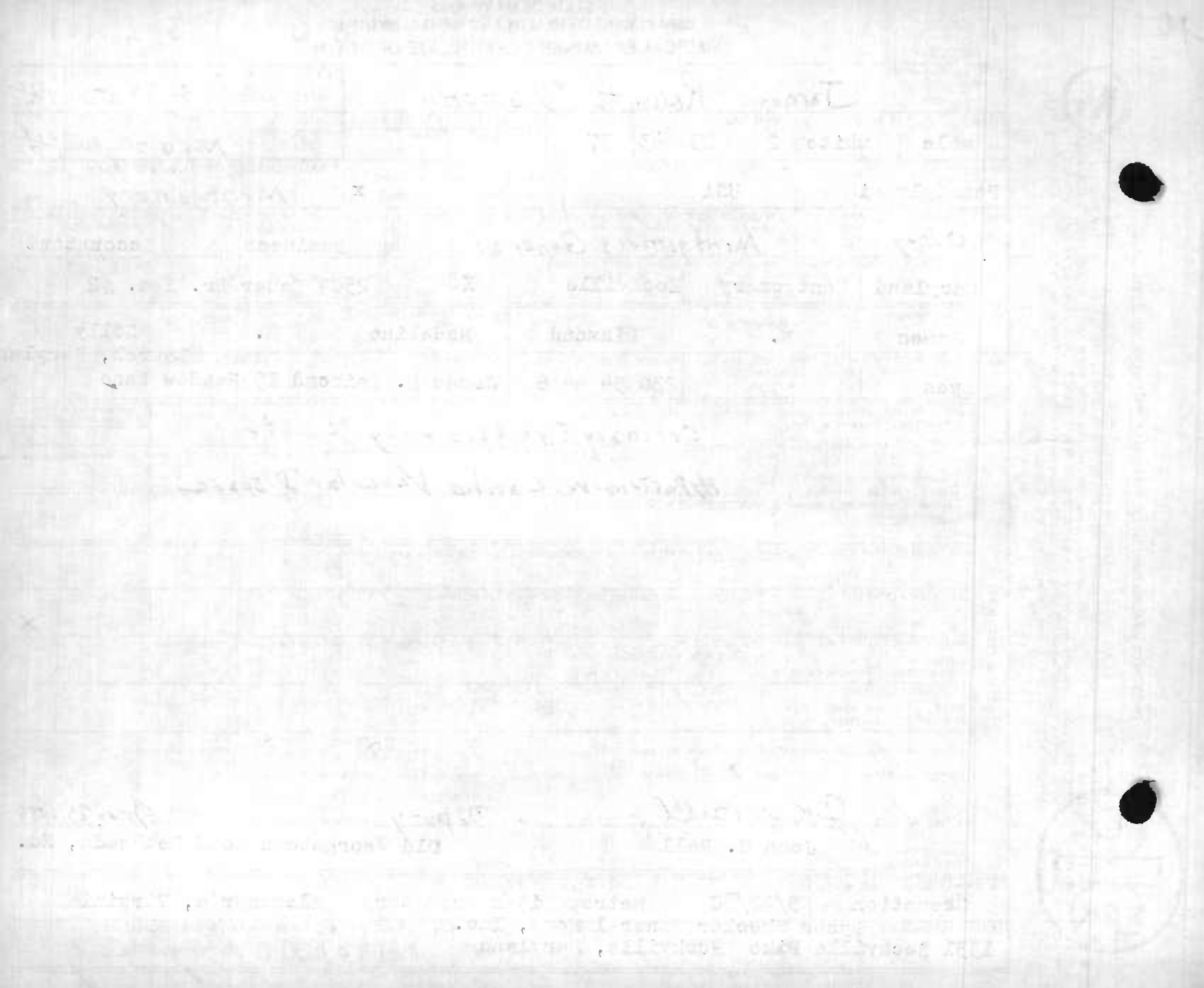
DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

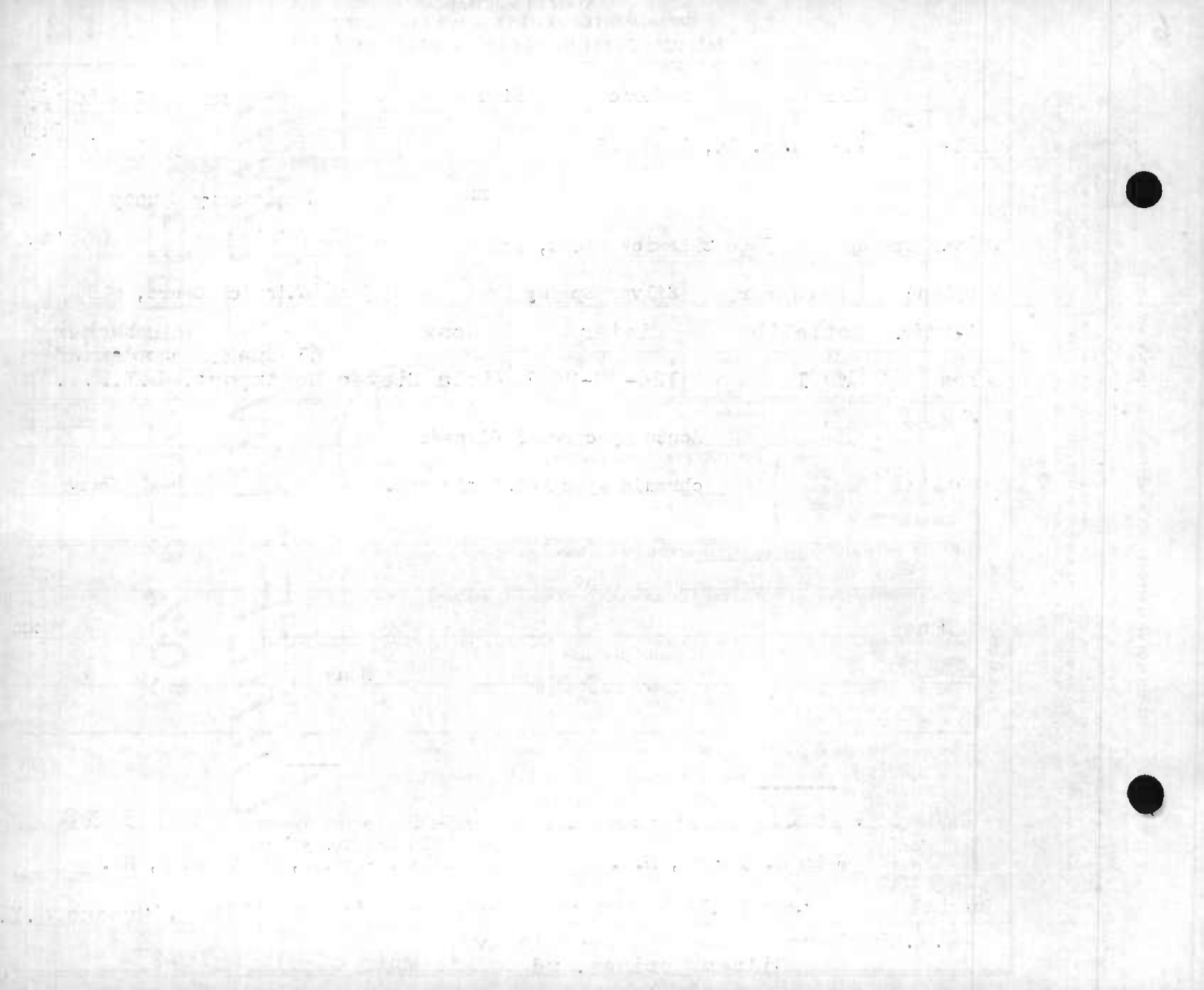
1- FOR  
STATE  
REGISTRAR

|   |         |  |  |   |   |  |   |   |
|---|---------|--|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |  | 2a. DATE KNOWN<br>OF ESTI-<br>MATED                            |   |   | 2b. HOUR<br>1 1/2 M  |   |   |
| James Robert Diamond  |         |  | 5-25-1980  |   |   | 1 1/2 M  |   |   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.                        | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE<br>PRONOUNCED<br>DEAD   |   | 2d. HOUR<br>1 1/2 M                             |
| male  | white   | 2 23 43  | 37   |   |   | May 25 1980  |   | 1 1/2 M   |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |   |
| Pennsylvania  |         | USA  |  |   |   | Montgomery MD.   |   |   |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)              |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |   |
| Olney   |         | Montgomery General   |  |   | Business  |  | Accountant  |   |
| 13a. STATE  |         |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| Maryland  |         |  | Montgomery   |   | Rockville   |  | 2509 Bauer Dr. Apt. #2  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                  |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |   |   |
| James H. Diamond  |         |  | Madeline M. Rolly  |   |   | yes 1971   |   |   |
| 16a. SOCIAL SECURITY NO.  |         |  | 17. INFORMANT  |   |   | ADDRESS  |   |   |
| 230 54 4486   |         |  | James H. Daimond   |   |   | 19 Meadow Lane Laurel, Maryland  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertensive Cardio Vascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |  |   |   |  |   |   |
| 19a. DATE OF OPERATION  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |  |  |   |   |  |   |   |
| ACTUAL<br>SIGNATURE   |         |  | TITLE (SPECIFY)  |   |   | DATE<br>SIGNED   |   |   |
| John G. Ball  |         |  | M.D. Deputy  |   |   | May 25, 1980   |   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         |  | ADDRESS  |   |   |  |   |   |
| John G. Ball  |         |  | Old Georgetown Road Bethesda, Md.                              |   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |   |
| Cremation   |         | 5/27/80  |  | Metropolitan Crematory  |   | Alexandria, Virginia   |   |   |
| 24. FUNERAL DIRECTOR  |         |  |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |   |   |
| Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Maryland   |         |  |  | MAY 29 1980   |   | Tyrone A. Brady  |   |   |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS ANTICIPATED. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE REGISTRAR  |  |               |  |  |  |   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH    |  |  |  |   |  |  |  |  |  | REG. NO. 13242              |  |
|--|--|---------------|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Charles Frederick Dieter   |  |               |  |  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5/12 19 80 |  |  |  |   |  |  |  |  |  | 2b. HOUR OF DEATH 5:00 P.M. |  |
| 3. SEX Male  |  | 4. RACE White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR Sep. 26, 1893   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.                     |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD 5/13 19 80   |  | 2d. HOUR OF DEATH 3:50 P.M.  |  |   |  |  |  |  |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.                       |  |   |  |  |  |  |  |                             |  |
| 10. CITY OR TOWN OF DEATH Silver Spring  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3406 Chiswick Court, #1B |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Post Office  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY US Gov't.                                      |  |   |  |  |  |  |  |                             |  |
| 13a. STATE Maryland  |  |               |  | 13b. COUNTY Montgomery   |  | 13c. CITY OR TOWN Silver Spring                             |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS 3406 Chiswick Court, #1B  |  |  |  |   |  |  |  |  |  |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST Martin Gottelibe Dieter   |  |               |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST Rosa Ambacher |  |  |  |   |  |  |  |   |  |  |  |  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes   |  |               |  | 16b. SOCIAL SECURITY NO. WW 1  |  | 17. INFORMANT 61 Sunken Meadow Rd Northport, L.I., N.Y.     |  |  |  |   |  |  |  |   |  |  |  |  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>chronic myocardial disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |               |  |  |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Years |  |  |  |  |  |                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>None  |  |               |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |                             |  |
| 19a. DATE OF OPERATION None  |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |  |  |                             |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None   |  |   |  |  |  |   |  |  |  |  |  |                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |  |  |  |  |                             |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |               |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |                             |  |
| ACTUAL SIGNATURE <i>John S. Rogers</i>   |  |               |  | TITLE (SPECIFY) Deputy   |  |   |  | DATE SIGNED 5/13/80  |  |   |  |  |  |   |  |  |  |  |  |                             |  |
| EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.   |  |               |  | ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |               |  | 23b. DATE May 16, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery        |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Middle Village, Queens, N.Y.                  |  |  |  |   |  |  |  |  |  |                             |  |
| 24. FUNERAL DIRECTOR NAME W. Chambers  |  |               |  | ADDRESS 8655 Georgia Ave Silver Springs, Md  |  |   |  | 25a. DATE REC'D. BY REGISTRAR MAY 19 1980  |  |   |  | 25b. REGISTRAR'S SIGNATURE <i>Richard McCreary</i>                               |  |   |  |  |  |  |  |                             |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETURNED TO THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | REG. NO. 13243  |  |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Irma L. Dillard</b> |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 4 19 80   |  | 2b. HOUR<br>M 5:35 P M  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>March 20, 1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75 YRS.</b>   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>5 8 19 80</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5504 Johnson Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired-Clerk Gen.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Acct. Office</b>  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |   |  |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Montgomery</b>                     |  | 13c. CITY OR TOWN<br><b>Bethesda</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5504-Johnson Avenue</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Josiah L. Dillard</b>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna - Winkleman</b>                        |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>578-32-8190-M</b>   |  | 17. INFORMANT ADDRESS<br><b>Ralph G. Dillard (Brother) 1575-Curlew Ave. Naples, Fla. 33942</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Obesity</b>   |  |  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE   |  |  |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |  | DATE SIGNED <b>5/9/80</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |  |  |  | ADDRESS<br><b>111 Penn Street</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |  |  | 23b. DATE<br><b>May 13, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. Wm. Lee's Sons Co.</b>  |  |  |  | ADDRESS<br><b>300 4th St., NE, Wash., D.C.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GLADYS Ramsey Donaldson</b>                      |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-28-80</b>  |   | 2b. HOUR<br><b>1:08 A.M.</b>                                    |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Cau.</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 16, 1916</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D.C.</b>                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Seventh Day Adventist Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |   |   |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>P.G.</b>   | 13c. CITY OR TOWN<br><b>Accokeek</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>Box 107</b>                                   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Luther Ramsey</b>                          |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hazel Unavailable</b>                       |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>          |  | 16b. SOCIAL SECURITY NO.<br><b>577-44-7735</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Leonard F. Donaldson, Sr. same as 13</b> |   |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>metastatic lung cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 1979</b> to <b>May 28, 1980</b> , that (I) (we) lost saw the deceased alive on <b>May 27, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |  |  |   |  |
| 22b. SIGNATURE<br><b>DJH - NAIDAK</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>5/28/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DJH - NAIDAK</b>   |  | 22e. ADDRESS<br><b>Belair Rd. Beltsville</b>                           |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-31-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Trinity Mem. Gardens Waldorf, Charles, Md.</b> |  |
| 23d. LOCATION<br>CITY OR TOWN  |  | 23e. DATE OF RECORD<br><b>JUN 5 1980</b>                               |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Huntt Funeral Home, Waldorf, Maryland</b>   |  | 25. STATE REGISTRAR<br><b>JUN 5 1980</b>                               |  |   |  |



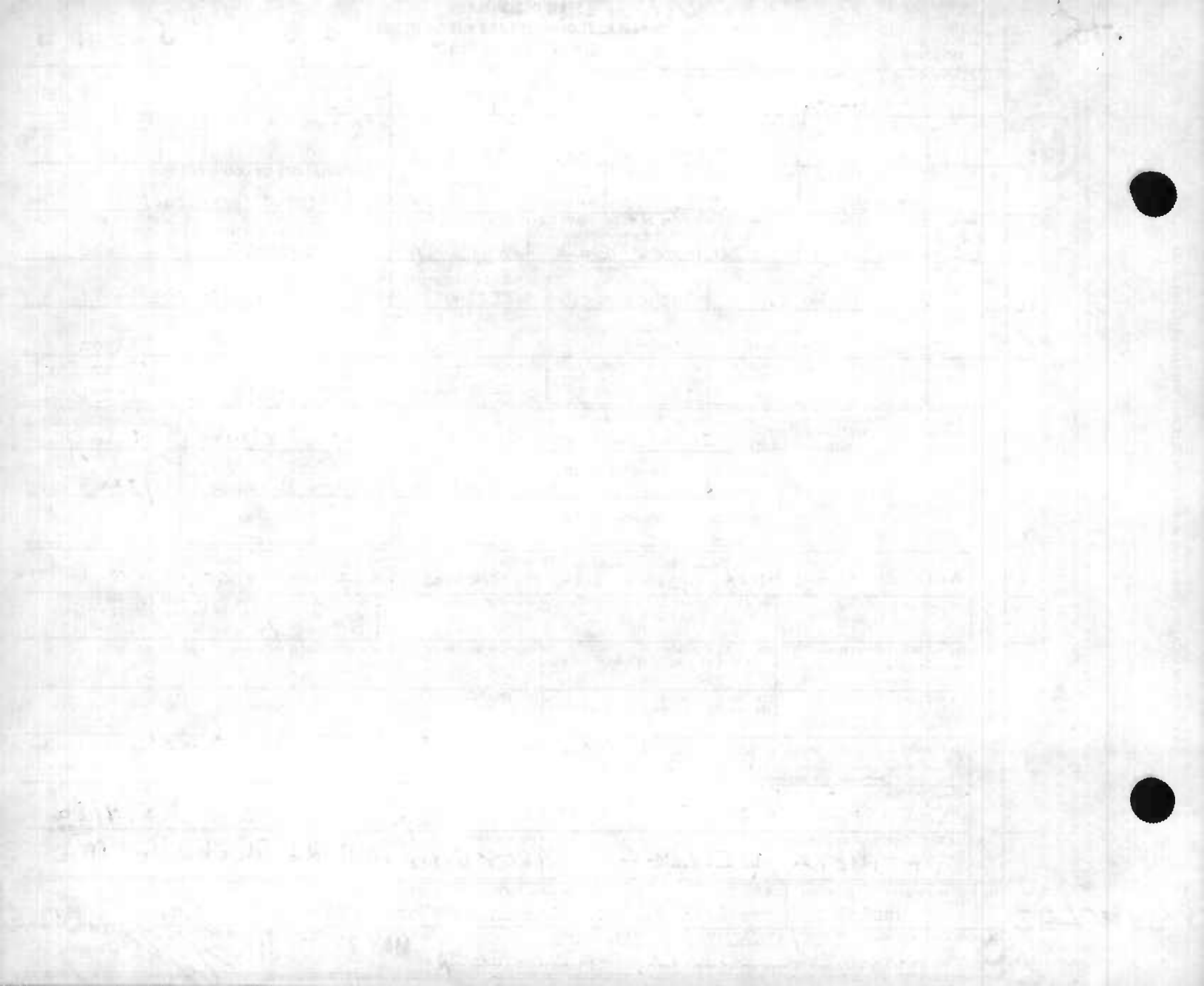
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8013245  |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Fannie Ellen Dorr</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/3/80</b>  |  |   |  | 2b. HOUR<br><b>9 P.M.</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 17 1890</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Mont.</b>   |  | 13c. CITY OR TOWN<br><b>Bethesda</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8200 Wisconsin Avenue</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Abraham Livesay</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Leona E. Wilson</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-50-0665</b>  |  | 17. INFORMANT<br><b>George Dorr</b>   |  | 2615 ADDRESS<br><b>Silver Spring</b>  |  | Silver Spring<br><b>Maryland</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>Cerebral Vascular Accident (stroke)</b><br><b>4/40</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b): <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c):<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>years</b> |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Arteriosclerotic Heart Disease with myocardial infarction of congestive failure</b>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 2</b> 19 <b>80</b> , to <b>May 3</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>May 3</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Patricia D Kellogg</b> MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>5/4/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PATRICIA KELLOGG</b>  |  |   |  | 22e. ADDRESS<br><b>809 Vicks M.H. Rd, Rockville, Md</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>May 6, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Md.</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HINES/RINALDI FUNERAL HOME</b>   |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>MAY 7 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey McBrady</b>  |  |  |  |
| 11800 New Hampshire Ave., Silver Spring, Md   |  |   |  |   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

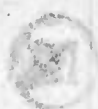
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |   |  |                                   | 8 0 1 3 2 4 6  |                                   |  |  |  |  |   |  |
|--|--|--|--|---|--|--|---|--|-----------------------------------|--|-----------------------------------|--|--|--|--|---|--|
| FOR<br>STATE<br>REGISTRAR  |  |  |  |   |  |  |   |  |                                   | REG. NO.   |                                   |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ellsworth Frank Dorsey</b>  |  |  |  |   |  |  |   |  |                                   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 4 1980</b>  |                                   |  |  | 2b. HOUR<br><b>2 PM</b>  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-10-14</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS. |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS |  | 7. IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY MD.</b>  |   |  |                                   |  |                                   |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WASHINGTON ADVENTIST</b> |  |   |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                                   | 12b. KIND OF BUSINESS OR INDUSTRY  |                                   |  |  |  |  |   |  |
| 13a. STATE<br><b>Md.</b>   |  |  |  |   |  |  |   |  |                                   | 13b. COUNTY<br><b>MONTG</b>  |                                   | 13c. CITY OR TOWN<br><b>Rockville</b>            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>212 FREDERICK AVE</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISIAH S. DORSEY</b>   |  |  |  |   |  |  |   |  |                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAUDE A. RIGGS</b>   |                                   |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>111111111</b>   |  | 17. INFORMANT ADDRESS<br><b>MARY Ellen Dorsey (wife) SAME AS #13</b>  |  |  |   |  |                                   |  |                                   |  |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1481</b><br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF PYLIFORM SINUS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b>   |                                   |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |   |  |                                   |  |                                   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |  |                                   |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |  |                                   |  |  |  |  |   |  |
| 22a. certify that (I) (this hospital) attended the deceased from <b>3/30</b> , 19 <b>80</b> , to <b>5/4</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>5/2</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |  |                                   |  |                                   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Maureen C. Brice</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |  |   | 22c. DATE SIGNED<br><b>5/5/80</b>  |                                   |  |                                   |  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KIRKLAND C. BRICE</b>  |  |  |  | 22e. ADDRESS<br><b>1600 CARROLL AVE TAKOMA PARK, MD</b>   |  |  |   |  |                                   |  |                                   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  |  | 23b. DATE<br><b>5-8-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BROOKE GROVE CEM.</b> |   |  |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LAYTONSVILLE MONTGOMERY MD.</b>   |                                   |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George P. Snowden</b>   |  |  |  | 24b. ADDRESS<br><b>246 N. WASH. ST. Rockville, Md.</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 8 1980</b>                             |                                   |  |                                   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |  |  |   |  |

MEDICAL CERTIFICATION

0902



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

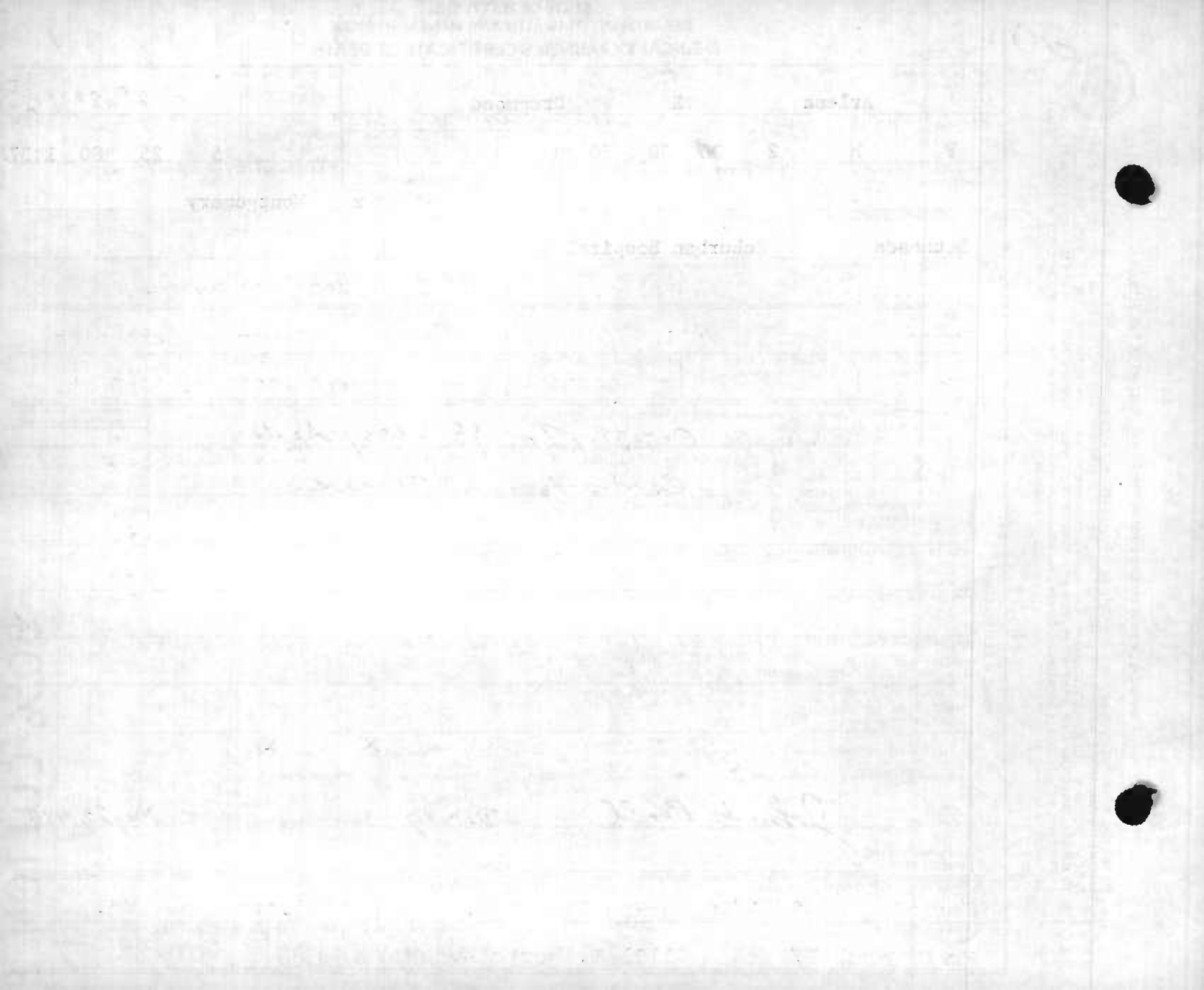
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |                     |  |   |  |   |
|---|---------------------|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Arlena E Drummond</b>  |                     |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br><b>5-25-1980</b>                      |  | 2b. HOUR<br>DAY MONTH<br><b>1:37 PM</b>   |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>N</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 20 30</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50 YRS.</b>   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.<br><b>5 25 1980</b>   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>5 25 1980</b>                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD   |   |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                     |  |   |  |   |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY         | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>4009 Wilsby Ave.</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Wall</b>   |                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Roberta Savoy Scroggins</b>                 |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                     | 16b. SOCIAL SECURITY NO.<br><b>220-20-8992</b>   |   | 17. INFORMANT ADDRESS<br><b>Ivan Drummond 2035 E. 32nd St.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>411- IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br><b>(b) Cerebro-Vascular Disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>(c)</b>  |                     |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                     |  |   |  |   |
| 19a. DATE OF OPERATION  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                     |  |   |  |   |
| ACTUAL SIGNATURE<br><b>John E Ball</b>  |                     | TITLE (SPECIFY)<br><b>M.D. Deputy</b>  |   | DATE SIGNED<br><b>May 25, 1980</b>   |   |
| EXAMINER'S NAME (TYPE OR PRINT)   |                     | ADDRESS  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                     | 23b. DATE<br><b>5/30/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cem.</b>                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>   |                     | ADDRESS<br><b>1101 E. North Ave</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 28 1980</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Melroody</b>                              |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 8013248  |  |  |  |  |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Belmont  |  | MIDDLE   |  | LAST<br>Ephraim  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>5/16/80  |  |
| 3 SEX<br>M  |  | 4 RACE<br>CAUCASIAN   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 3, 1895  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS   |  | 7b HOUR<br>6:50 A.M.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery Co MD  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Rockville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HEBREW HOME OF GREATER WASH. |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ACCOUNTANT                  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>U.S.GOV'T   |  |
| 13a STATE<br>MARYLAND   |  | 13b COUNTY<br>MONTGOM'Y   |  | 13c CITY OR TOWN<br>ROCKVILLE  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>6121 MONTROSE RD.   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM --- EPHRAIM  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>PAULINE --- (unknown)   |  |  |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW I  |  | 17 INFORMANT ADDRESS<br>NORMAN GLASSER, 4818 ASPEN HILL RD. ROCKV'E  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Prob. Dysrhythmia</u><br><u>4292</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>ASCAD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASCAD</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Severe peripheral vasc disease</u>  |  |   |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a I certify that <u>the hospital</u> attended the deceased from <u>5/19</u> 19 <u>77</u> to <u>5/16</u> 19 <u>80</u> , that (1) <u>we</u> lost<br>saw the deceased alive on <u>5/16</u> 19 <u>80</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If <u>we</u> did <u>not</u> view the body after death.       |  |   |  |  |  |  |  |   |  |
| 22b SIGNATURE<br><u>Marsha Wallace MD</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |  |  | 22c DATE SIGNED<br><u>5/16/80</u>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MARSHA T. WALLACE MD</u>   |  |   |  | 22e ADDRESS<br><u>6121 Montrose Rd Rockville Md</u>  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b DATE<br>5/18/80   |  | 23c NAME OF CEMETERY OR CREMATORY<br>MT. LEBANON   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Hyattsville P.G.Md.</u>                        |  |   |  |
| 24 FUNERAL DIRECTOR<br><u>DANZANSKY-GOLDBERG MEMORIAL CHAP., ROCKVILLE, MD</u>  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br><u>MAY 22 1980</u>   |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   |   |  |   |  |  |
|--|--|--|---|---|---|--|---|--|--|
| CERTIFICATE OF DEATH   |  |  |   |   |   |  |   |  |  |
| 1. FOR STATE REGISTRAR   |  |  |   |   | REG. NO.  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |   |   | 2a. DATE OF DEATH   |  |   |  |  |
| FIRST MIDDLE LAST<br><b>CHARLOTTE - EVANS</b>  |  |  |   |   | MONTH DAY YEAR HOUR<br><b>5 17 80 5:00 PM</b>                       |  |   |  |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR   |  |
| <b>FEMALE</b>  |  | <b>WHITE</b>   |   | MONTH DAY YEAR<br><b>10 25 94</b>   |   | <b>85 YRS.</b>   |   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |
| <b>PA</b>  |  | <b>USA</b>   |   |   |   | <b>MONTG.</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| <b>SILVER SPRINGS</b>  |  | <b>B&amp;L PRE HEALTH CENTER</b>   |   |   |   | <b>Homemaker</b>   |   | <b>Home</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Montgomery Rockville</b>   |  |  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | <b>199 Rollins Avenue</b>   |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)<br><b>Phillip Blatz</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)<br><b>Anna M. Koch</b> |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>213-74-9806</b>                      |  | 17. INFORMANT ADDRESS<br><b>Clement H. Evans MD 20906<br/>3200 Weeping Willow Ct. Silver Spring</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |   |   |  |   |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |   |   |   |  |   |  |  |
| IMMEDIATE CAUSE (a) <b>Coronary atherosclerosis</b>  |  |  |   |   |   |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer of the kidney</b>   |  |  |   |   |   |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>1890</b>   |  |  |   |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |   |   |  |   |  |  |
| MEDICAL CERTIFICATION  |  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 5, 1980</b> to <b>May 17, 1980</b> , that (I) (we) lost saw the deceased alive on <b>May 15, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE <b>Michael R. Dobardse MD</b>   |  |  |   |   | DEGREE  |  | 22c. DATE SIGNED <b>May 17 1980</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael R. Dobardse MD</b>  |  |  |   |   | 22e. ADDRESS <b>13975 Connecticut Ave Silver Spring MD</b>          |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  | 23b. DATE <b>May 20, 1980</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bladensburg Maryland</b>                                 |  |  |
| 24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Homes, P.A.</b>   |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1980</b>                               |   | 25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>           |  |
| 25c. ADDRESS <b>7557 Wisconsin Avenue Bethesda, MD</b>   |  |  |   |   |   |  |   |  |  |

(M)

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DHMH-17  
(VRA15 ME (5))  
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |  |  |  |   |  | REG. NO. 13250  |  |                            |  |
|---|--|-------------------------|--|--|--|--|--|---|--|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRISON MASON FAITH</b>   |  |                         |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>5/25/80</b> |  | 2b. HOUR<br><b>2:21 PM</b> |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b> |  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>27</b> YEAR <b>20</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>59</b> YRS.                                  |  | IF UNDER 1 YR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b>  |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Indiana</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                    |  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Consultant</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Banking</b>                                     |  |                            |  |
| 13a. STATE<br><b>U.S.</b>   |  |                         |  | 13b. CITY OR TOWN<br><b>Virgin Islands n/a</b>   |  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>Pineapple Beach Resort</b>                                    |  |                            |  |
| 14. FATHER'S NAME<br>FIRST <b>Carlton</b> MIDDLE <b>Faith</b> LAST <b>Grace</b>   |  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Grace</b> MIDDLE <b>Mason</b> LAST <b>Mason</b>   |  |  |  |   |  |   |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  |  |  | 17. INFORMANT<br><b>Jerry Bever-</b>  |  |   |  |                            |  |
|   |  |                         |  |  |  |  |  | 17a. ADDRESS<br><b>2115 Adventurine Way Silver Spring, Md.</b>  |  |   |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>(b) Cardio Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>411-</b>   |  |                         |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                         |  |  |  |  |  |   |  |   |  |                            |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  |                            |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                            |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |  |  |   |  |   |  |                            |  |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>   |  |                         |  | TITLE (SPECIFY)<br><b>Deputy</b>   |  |  |  | DATE SIGNED<br><b>May 25 1980</b>   |  |   |  |                            |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John G. Ball</b>   |  |                         |  | ADDRESS<br><b>7936 Old Georgetown Rd. Bethesda, Maryland</b>   |  |  |  |   |  |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>5-29-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Vista Mem. Gardens Woodlawn Park Cem.</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Miami, Florida</b>                     |  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Capitol Funeral Service-Fairfax, Va.</b>   |  |                         |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Larry McBrady</b>                                      |  |                            |  |

Capital Federal Service-Paterson, Va.

Initial 2-22-44 Goodwin Park Co. April, 1944

John E. Ball  
1940 Old Georgetown Rd.  
Bethesda, Md.

207-07-0001 Jerry Meyer - River Bridge, Md.

Carlton Grace Mason

U.S. Virgin Islands

Constant

Montgomery County

2/21/44

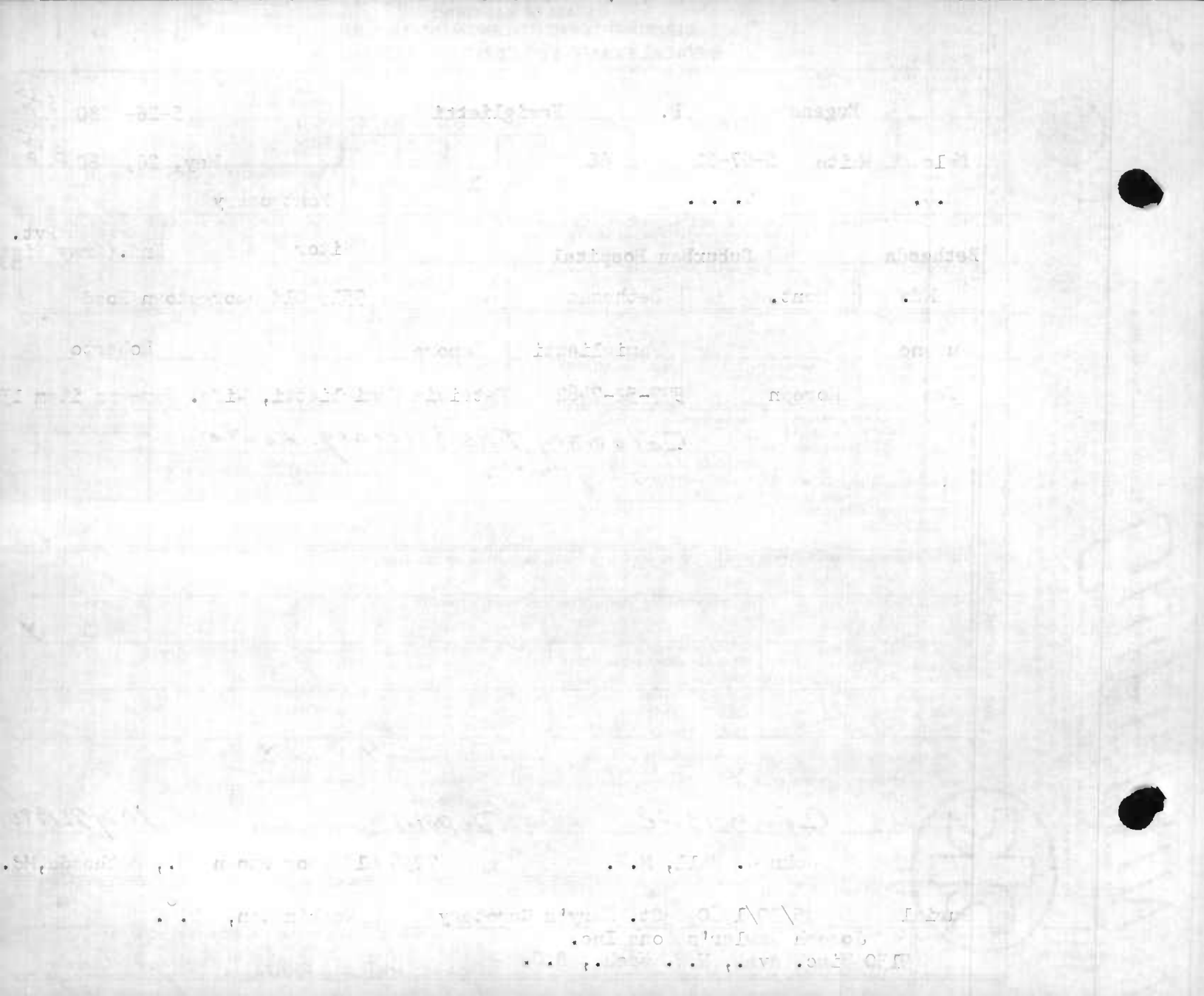
2/21/44



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |   |   |   |  |   |  |   |  | REG. NO. 13251 |  |
|---|----------------------|---|---|---|--|---|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Eugene P. Famiglietti</b>  |                      |   |   |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5-26-1980</b> |  | 2b. HOUR <b>5:15 PM</b>   |  |                |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>5-07-32</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>48 YRS.</b> | IF UNDER 1 YR. MONTHS DAYS HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD <b>May 26, 1980</b>  |  | 2d. HOUR <b>5:15 PM</b>   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                  |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Editor</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Ind. (Army Time)</b>                      |  |                |  |
| 13a. STATE <b>Md.</b>   |                      | 13b. COUNTY <b>Mont.</b>  |   | 13c. CITY OR TOWN <b>Bethesda</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 13e. STREET ADDRESS <b>9519 Old Georgetown Road</b>                                 |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Eugene Famiglietti</b>  |                      |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Lenora Roberto</b>   |  |   |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>  |                      | 16b. SOCIAL SECURITY NO. <b>577-52-7462</b>   |   | 17. INFORMANT ADDRESS <b>Patricia Famiglietti, Wife. Same as item 13</b>  |  |   |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute.</b><br>411-<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |                      |   |   |   |  |   |  |   |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                      |   |   |   |  |   |  |   |  |                |  |
| 19a. DATE OF OPERATION  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                      |   |   |   |  |   |  |   |  |                |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>  |                      | TITLE (SPECIFY) <b>Deputy</b>   |   |   |  | DATE SIGNED <b>May 26, 1980</b>   |  |   |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>   |                      | ADDRESS <b>7936 Old Georgetown Rd., Bethesda, Md.</b>   |   |   |  |   |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                      | 23b. DATE <b>5/30/1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>                          |  |   |  |                |  |
| 24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b>  |                      |   |   | ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 2 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>                                   |  |                |  |



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Reba               |  | FIRST MIDDLE LAST<br>FASIMPAUR  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>5 23 80  |  | 2b HOUR<br>4 40 P M  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>white   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 26, 1917   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.                                  |  |
| 10 CITY OR TOWN OF DEATH<br>Silver Spring                |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>OWN HOME   |  |
| 13a STATE<br>MARYLAND                                    |  | 13b COUNTY<br>Montgomery  |  | 13c CITY OR TOWN<br>Silver Spring  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>PHILIP GLAUSER  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>JENNIE BERKOWITZ   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>181-10-5089                          |  |
| 17 INFORMANT<br>EDWARD B. FASIMPAUR,                     |  | ADDRESS<br>1001 SPRING STREET, #514<br>SILVER SPRING, MARYLAND  |  |  |  |  |  |

11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA LIVER

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

4 months

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a I certify that (I) <del>(this hospital)</del> attended the deceased from <u>SEPTEMBER</u> 19 <u>76</u> , to <u>MAY 23</u> 19 <u>80</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>MAY 23</u> 19 <u>80</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did)</del> <del>(do not)</del> view the body after death. |  |   |  |   |  |  |  |
| 22b SIGNATURE<br>Hubert J. Alpert   |  | DEGREE<br>M.D.  |  | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN |  | 22c DATE SIGNED<br>23 May 80   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>HUBERT J. ALPERT, MD  |  | 22e ADDRESS<br>3630 FENTON ST<br>SILVER SPRING, MD 20906              |  |   |  |  |  |

|   |  |                       |  |  |  |   |  |
|---|--|-----------------------|--|--|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b DATE<br>5/25/1980 |  | 23c NAME OF CEMETERY OR CREMATORY<br>ROOSEVELT MEMORIAL PARK |  | 23d LOCATION<br>TREVOSE, BUCK CNTY., PENNSYLVANIA |  |
| 24 FUNERAL DIRECTOR<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 CARROLL STREET, N.W., WASHINGTON, D.C. |  |                       |  |  |  |   |  |

WILLIAM N. STEIN HERREN MEMORIAL FUNERAL HOME  
227 CARROLL STREET, N.W., WASHINGTON, D.C.  
5/25/1980  
ROOSEVELT MEMORIAL PARK  
KREWE, BUCK CITY, KENNEDY

PHILLY  
CLARENCE  
JIMMY  
NEW CITY  
1001 SPRING STREET, 401  
SILVER SPRING, MARYLAND  
EDWARD J. FASTINAK

NEW YORK  
HONORARY  
AT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |  |   |  |  |
|---|--|--|--|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.   |  |  |  |   |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |  |  |   | 2a DATE OF DEATH MONTH DAY YEAR                    |  |  |  |   | 2b HOUR  |  |
| Sarah Firestone   |  |  |  |   | 5/25/80 May 25 1980                                |  |  |  |   | 9:56pm   |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                               |  | 7 UNDER 1 YEAR MONTHS DAYS   |   | 7 UNDER 24 HRS HOURS MIN   |  |
| Female  |  | White  |  | May 3, 1903   |  | 77 years YRS   |  |  |   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |   |  |  |
| RUSSIA  |  | United States  |  |   |  | Montgomery County MD   |  |  |   |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b KIND OF BUSINESS OR INDUSTRY   |   |  |  |
| Silver Spring   |  | Holy Cross Hospital  |  |   |  | Housewife  |  |  |   |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13b COUNTY   |  | 13c CITY OR TOWN                         |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| Maryland  |  |  |  |   | Montgomery   |  | Silver Spring                            |  | 13e STREET ADDRESS  |  |  |
|   |  |  |  |   |  |  |  |  | 11625 Lebaron Terrace   |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST          |  |  |  |   |  |  |
| Mendel Stein  |  |  |  |   | Jennie Gorowitz                                    |  |  |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |   | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) |  | 17 INFORMANT ADDRESS                     |  |   |  |  |
| No  |  |  |  |   | 080-28-0830  |  | Same as No. 13 daughter, Mildred E. Blum |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u>   |  |  |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  |  |  |   |  |  |  |  |   | 1 hr   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension + arteriosclerotic CVD</u>   |  |  |  |   |  |  |  |  |   | 20 yrs.  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |  |   |  |  |
| 19a DATE OF OPERATION   |  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 19 <u>65</u> , to <u>5-25</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5-23</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |   |  |  |
| 22b SIGNATURE   |  |  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c DATE SIGNED  |  |
| Bernard H. Ostrow   |  |  |  |   |  |  |  |  |   | 5-26-80  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e ADDRESS   |  |  |  |  |   |  |  |
| BERNARD H. OSTROW   |  |  |  | 5225 POOKS Hill Rd  |  |  |  | BETH, MD   |   |  |  |
| 23a BURIAL CREMATION, REMOVAL (SPECIFY)   |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION CITY OR TOWN COUNTY STATE                       |  |  |   |  |  |
| Burial  |  | 5/27/80  |  | Cedar Park Cemetery   |  | Paramus, New Jersey  |  |  |   |  |  |
| 24 FUNERAL DIRECTOR Donald M. Stein Hebrew Memorial F.H.  |  |  |  |   |  | 25a DATE RECEIVED BY REGISTRAR MAY 26 1980                   |  | 25b REGISTRAR'S SIGNATURE  |   |  |  |
| 232 Carroll Street, N. W. Washington, D. C.   |  |  |  |   |  |  |  |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |   |   |                                   |   |  |  |
|--|--|--|--|--|---|---|-----------------------------------|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |  | CERTIFICATE OF DEATH  |   |                                   |   |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |  | 2a DATE OF DEATH  |   |                                   |   |  |  |
| FIRST MIDDLE LAST<br>William Bartlett Fletcher Jr.   |  |  |  |  | MONTH DAY YEAR<br>May 31 1980                                   |   |                                   |   |  |  |
| 2b HOUR<br>0135 M  |  |  |  |  |   |   |                                   |   |  |  |
| 3 SEX<br>male  |  | 4 RACE<br>Caucasian  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 03 1900  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |                                   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Massachusetts  |  | 7b CITIZEN OF WHAT COUNTRY?<br>United States   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                        |                                   |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Naval Officer    |                                   | 12b KIND OF BUSINESS OR INDUSTRY<br>U.S. Navy   |  |  |
| 13a STATE<br>Pennsylvania  |  |  |  |  | 13b COUNTY<br>Bl Rg. Summit                                     |   | 13c STREET ADDRESS<br>P.O. Box 44 |   |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Bartlett Fletcher   |  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Malena Asserson |   |                                   |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE YEAR OR DATES)<br>1920-1950  |  | 17 INFORMANT<br>Geraldine Free Fletcher  |   | ADDRESS<br>Same as item 13.   |                                   |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Acute Broncho Pneumonia</u><br>485-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |   |   |                                   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |   |                                   |   |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                                   |   |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                                   |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>22 MAY 19 80</u> , to <u>31 MAY 19 80</u> , that (I) (we) lost<br>saw the deceased alive on <u>31 MAY 19 80</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.  |  |  |  |  |   |   |                                   |   |  |  |
| 22b SIGNATURE<br><u>T. Marshall</u>  |  |  |  | 22c DATE SIGNED<br><u>31 MAY 80</u>  |   |   |                                   |   |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>THOMAS J. MARSHALL</u>  |  |  |  | 22e ADDRESS<br><u>NATIONAL NAVY MED. CNTR., BETHA MD</u>   |   |   |                                   |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b DATE<br>6/4/1980   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Arlington National  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington D.C.                        |                                   |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Gawlers Funeral Home Wisconsin Ave. Wash., D.C.   |  |  |  | 25 DATE RECEIVED BY REGISTRAR<br>JUN 6 1980  |   |   |                                   | 25 REGISTRAR'S SIGNATURE  |  |  |

MEDICAL CERTIFICATION



11.11.11

20 MAY 2011

11.11.11

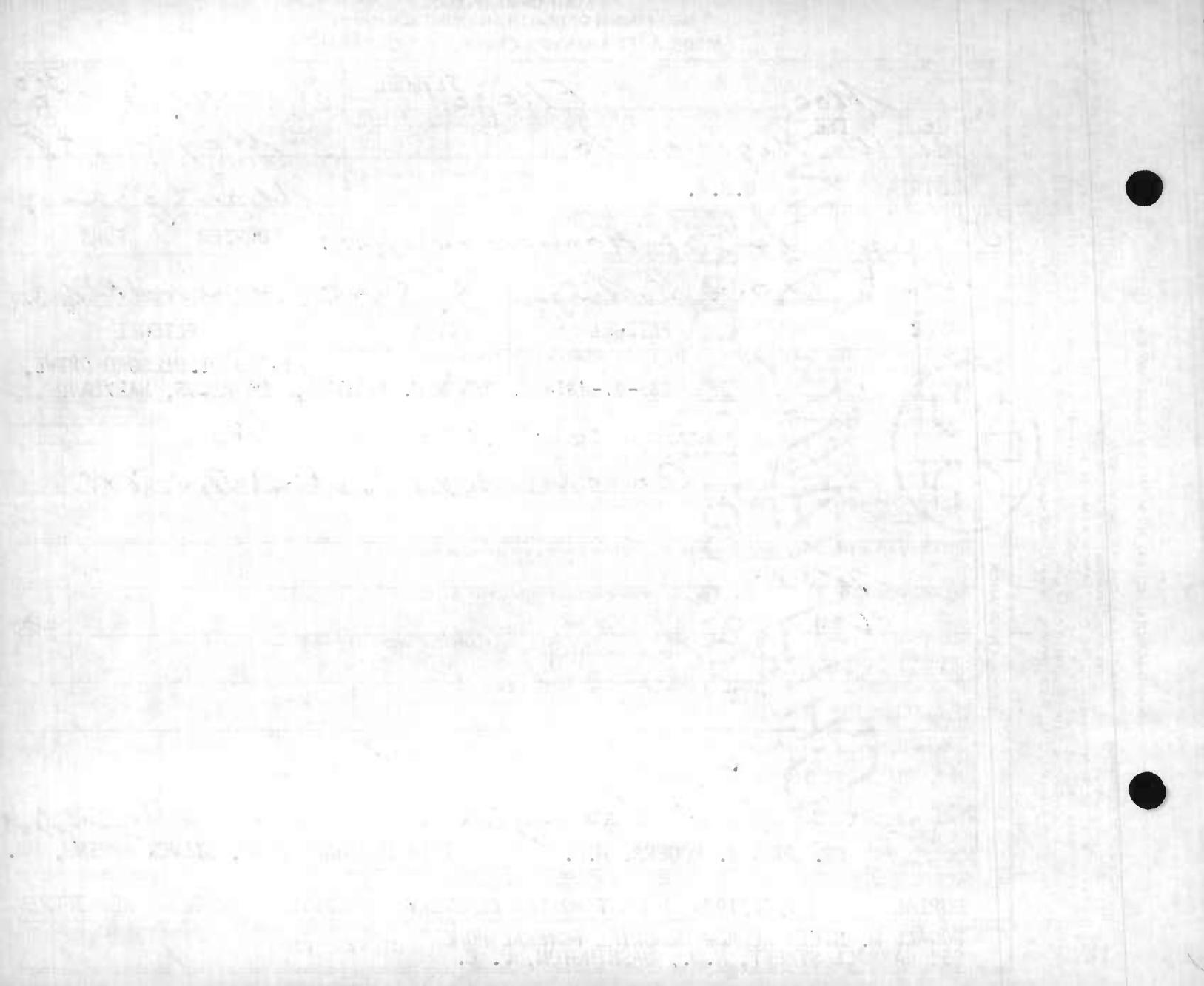
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30M 7/73

| FOR<br>1- STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                  |  |   |  |   |  | REG. NO.<br>13255  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>MOE   |  | MIDDLE<br>FLIEGEL   |  | LAST<br>FLIEGEL   |  | 2a. DATE OF KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> MAY 28 1980 |  | 2b. HOUR<br>8 M   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug 17 01 78  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>78 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 7c. DATE<br>PRONOUNCED<br>DEAD MAY 28 1980  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>AUSTRIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Sil. Spg.   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>14508 Homcrest Rd Apt 1325 |  | 12a. USUAL OCCUPATION (TYPE OF WORK)<br>FURRIER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FURS   |  |  |  |   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Mont  |  | 13c. CITY OR TOWN<br>Sil. Spg   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>14508 Homcrest Rd Apt 1325  |  |   |  |
| 14. FATHER'S NAME<br>MAYER   |  | MIDDLE<br>FLIEGEL  |  | 15. MOTHER'S MAIDEN NAME<br>CIVIA   |  | MIDDLE<br>FLIEGEL   |  | LAST<br>FLIEGEL  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>085-01-4816  |  | 17. INFORMANT<br>MYRON H. FLIEGEL   |  | ADDRESS<br>10955 MIDDLEBORO DRIVE,<br>DAMASCUS, MARYLAND  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. }<br>(b) <u>Chronic Myocardial Dis</u> yrs.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>None</u>   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><u>None</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |  |  |   |  |
| ACTUAL<br>SIGNATURE<br><u>Dr. John S. Rogers</u>   |  | TITLE (SPECIFY)<br>M.D.  |  | MEDICAL EXAMINER  |  |   |  | DATE<br>SIGNED MAY 28 1980   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>DR. JOHN S. ROGERS, M.D.   |  | ADDRESS<br>1919 SEMINARY ROAD, SILVER SPRING, MD.  |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>5/30/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MOUNT MORIAH CEMETERY   |  | 23d. LOCATION<br>CITY OR TOWN<br>FAIRVIEW   |  | COUNTY<br>BERGEN   |  | STATE<br>NEW JERSEY   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 2 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |  |  |   |  |
| 232 CARROLL STREET, N.W., WASHINGTON, D. C.  |  |  |  |   |  |   |  |  |  |   |  |



6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

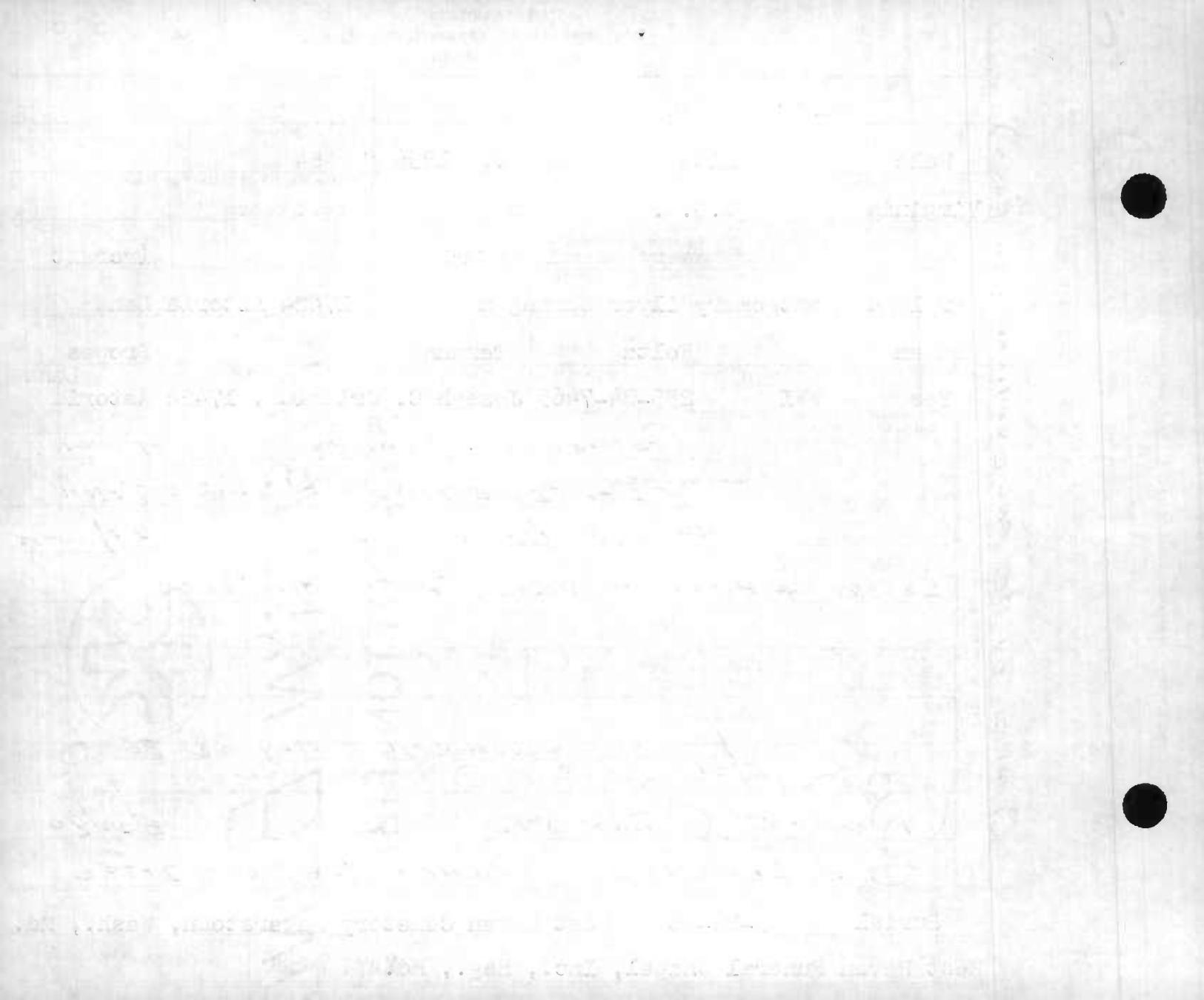
CLEARED BY MEDICAL EXAMINER (D. BAL.)

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |  |  | B 0 1 3 2 5 6   |  |
|--|---|--|--|---|--|
| 1- FOR STATE REGISTRAR   |   |  |  | REG. NO.  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William C. Foltz   |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>May 22, 1980  |   | 2b HOUR<br>6:45AM  |
| 3 SEX<br>Male  | 4 RACE<br>White   | 5 DATE OF BIRTH MONTH DAY YEAR<br>May 6, 1896  | 6 AGE (IN YEARS [LAST BIRTHDAY])<br>84 YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Olney  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Aircraft                       |   | 12b KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE 13b COUNTY 13c CITY OR TOWN<br>Maryland Montgomery Silver Spring  |   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>17424 Astoria Lane  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Reuben Foltz   |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Texanna Propes                                    |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |   | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WWI   | 17 INFORMANT ADDRESS<br>Joseph C. Griffith, 17424 Astoria Lane                                 |   |  |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CACHERIA + INANITION</u><br>2080<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>DEHYDRATION + RENOSIS TERN.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <u>ACUTE LEUKEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 MONTHS</u> |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>SEVERE ARTERIO SCLEROSIS; CARCINOMA (BLON)</u>   |   |  |  |   |  |
| 19a DATE OF OPERATION  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                      |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>NOVEMBER 26</u> 19 <u>76</u> to <u>MAY 22</u> 19 <u>80</u> that (1) (we) last saw the deceased alive on <u>5/21</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)   |   |  |  |   |  |
| 22b. SIGNATURE<br><u>Donald E. Lewis</u>   |   | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>5/22/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. R. LEWIS M.D.  |   | 22e. ADDRESS<br>OLNEY, MARYLAND 20832  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>5-24-80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Rest Haven Cemetery Hagerstown, Wash., Md.               |   | 23d. LOCATION CITY OR TOWN COUNTY STATE  |
| 24. FUNERAL DIRECTOR NAME<br>Rest Haven Funeral Chapel, Inc., Hag., Md.  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 27 1980   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Notary Public</u>   |

1302

BP









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |  |  |                                   |  |
|---|--|---|--|---|---|--|--|-----------------------------------|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  |   |  |   | CERTIFICATE OF DEATH  |  |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH   |  |  |                                   |  |
| Samuel Russell Frantom  |  |   |  |   | May 2, 1980   |  |  |                                   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | 7b. HOUR                          |  |
| Male  |  | White   |  | Jan. 13, 1907   |   | 73   |  | 11:10 P.M.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Md.   |  | U.S.A.  |  |   |   | Montgomery   |  | Jerrys Arco                       |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Takoma Park   |  | Washington Adventist Hospital   |  |   |   | Mechanic   |  |                                   |  |
| 13a. STATE  |  |   |  |   | 13b. CITY OR TOWN   |  | 13c. STREET ADDRESS  |                                   |  |
| Md.   |  |   |  |   | P.G.  |  | Mt. Rainier  |                                   |  |
| 14. FATHER'S NAME   |  |   |  |   | 15. MOTHER'S MAIDEN NAME  |  |  |                                   |  |
| Clarence D. Frantom   |  |   |  |   | E. Rector   |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |                                   |  |
| No  |  |   |  |   | 579-03-2974   |  | Evelyn D. Frantom  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |                                   |  |
| PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>spontaneous</i>   |  |   |  |   |   |  |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>heart failure</i>  |  |   |  |   |   |  |  |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>myocardial infarction</i>  |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (DO NOT RELATE TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a))                   |  |   |  |   | <i>coronary heart disease</i>                                       |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
|   |  |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |                                   |  |
|   |  | HOUR A.M. MONTH DAY YEAR  |  |   |   |  |  |                                   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY  |  | 21f. LOCATION   |   |  |  |                                   |  |
| AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | STREET CITY OR TOWN COUNTY STATE  |   |  |  |                                   |  |
| 22a. SIGNATURE  |  | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |   |  |  |                                   |  |
| <i>Lewis H. Dennis</i>  |  | Lewis H. Dennis, M.D.   |  |   |   |  |  |                                   |  |
| 22c. DATE SIGNED  |  | 22d. ADDRESS  |  |   |   |  |  |                                   |  |
| 5-5-80  |  | 831 Univ. Blvd. E. Silver Spring, Md.   |  |   |   |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION  |  | 23e. STATE                        |  |
| Burial  |  | 5-6-80  |  | Ft. Lincoln Cemetery  |   | Brentwood  |  | P.G. Md.                          |  |
| 24. FUNERAL DIRECTOR  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR                                       |  |  |                                   |  |
| F. Gasch's Sons F.H. P.A. Hyattsville, Md.  |  |   |  |   | MAY 6 1980  |  |  |                                   |  |
| 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |   |  |  |                                   |  |
| <i>Henry McCreedy</i>   |  |   |  |   |   |  |  |                                   |  |

of 11

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Classroom

*Journal of Management Education* 30(6)p.789-804

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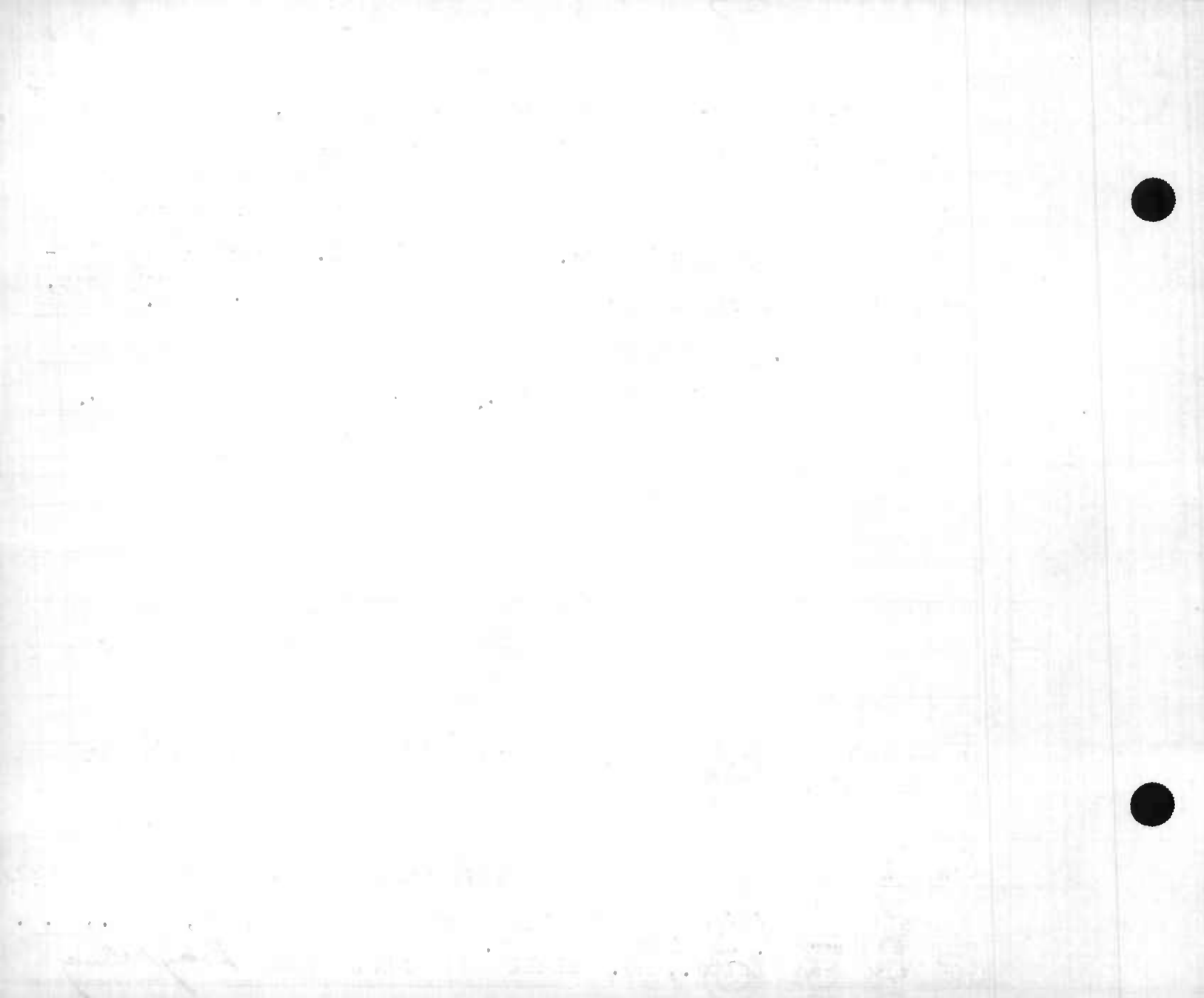
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |         |  |                                 |  |  |
|--|---------|--|---------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE OF DEATH  |                                 | 2b. HOUR   |  |
| DECEASED NAME (TYPE OR PRINT)  |         | MONTH DAY YEAR   |                                 | M  |  |
| Helen M. GASSAWAY  |         | MAY 29, 1980   |                                 | 11:00 AM   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR   |  |
| Female   | White   | MONTH DAY YEAR   | 83                              | MONTHS DAYS HOURS MIN  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7c. CITIZEN OF WHAT COUNTRY?   |                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Maryland   |         | USA  |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Gaithersburg   |         | 403 Russell Ave. # 302   |                                 | Asst. Director Nursing-  |  |
| 13a. STATE   |         | 13b. COUNTY  |                                 | 13c. STREET ADDRESS  |  |
| Maryland   |         | Montgomery   |                                 | 403 Russell Ave. # 302   |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |                                 | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |
| John H. Gassaway   |         | Helen Muncaster  |                                 | No   |  |
| 17. INFORMANT  |         | 18. SOCIAL SECURITY NO.  |                                 | 19. ADDRESS  |  |
| Mr. Joseph Henderson   |         | 219 30 8603  |                                 | Md.  |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> (b) <u>Atherosclerotic Heart Disease</u> (c) <u></u>  |         |  |                                 |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>   |         |  |                                 |  |  |
| 21a. DATE OF OPERATION   |         | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 | 21c. AUTOPSY?  |  |
|  |         |  |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |         | 22b. TIME OF INJURY  |                                 | 22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
|  |         | HOUR A.M. MONTH DAY YEAR   |                                 |  |  |
| 23a. INJURY OCCURRED   |         | 23b. PLACE OF INJURY   |                                 | 23c. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                 | STREET CITY OR TOWN COUNTY STATE   |  |
| 24. I certify that (a) (this hospital) attended the deceased from <u>March 19 79</u> to <u>December 19 79</u> , that (b) (we) lost   |         |  |                                 |  |  |
| saw the deceased alive on <u>11/30</u> 19 <u>79</u> , and that (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we (I) did (did not) view the body after death. |         |  |                                 |  |  |
| 25a. SIGNATURE   |         | 25b. DEGREE  |                                 | 25c. DATE SIGNED   |  |
| <u>John G. Lodmell MD</u>  |         | MD   |                                 | 5/29/80  |  |
| 26a. PHYSICIAN'S NAME (TYPE OR PRINT)  |         | 26b. ADDRESS   |                                 | 26c. REGISTERAR'S SIGNATURE  |  |
| John G. Lodmell MD   |         | 18111 PRINCE PHILIP DR. OLNEY MD, 20822  |                                 | <u>Rita J. McCreedy</u>  |  |
| 27a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 27b. DATE  |                                 | 27c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |         | 6/5/80   |                                 | Oak Hill Cemetery  |  |
| 28a. FUNERAL DIRECTOR NAME   |         | 28b. DATE REC'D. BY REGISTRAR  |                                 | 28c. REGISTRAR'S SIGNATURE   |  |
| Henry W. Jenkins & Sons Co.  |         | JUN 5 1980   |                                 | <u>Rita J. McCreedy</u>  |  |
| 4905 York Road Balto., Md. 21212   |         |  |                                 |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  | 8 0 1 3 2 6 0  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST<br>GEORGE EUGENE GAVLE  |  |  |  | MONTH DAY YEAR<br>5 21 80  |  | 2b. HOUR<br>9:35 A.M.  |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>CAUCASIAN  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>July 22, 1913   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Montana  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery Co. MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>BETHESDA  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SUBURBAN HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Auditor  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Montgomery Bethesda   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>9311 E. Parkhill Drive  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Martin Gavle   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NOT AVAILABLE  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>yes WW II  |  |  |  | 16b. SOCIAL SECURITY NO.<br>517-10-6004  |  | 17 INFORMANT<br>ADDRESS<br>Isabel E. Gavle, Same as #13  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory failure -</u><br>3570<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Sullivan - Barrie Syndrome</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Multiple lung abscesses</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Instant</u><br><u>8 weeks</u> |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Thurs</u> 19 <u>80</u> , to <u>21 May</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>20 May</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Horace W. Bernton</u><br>DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br><u>21 May '80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Horace W. Bernton, M.D.  |  |  |  | 22e. ADDRESS<br>4743 Bradley Blvd. Chevy Chase, MD 20015   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>5/23/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Culpeper Nat. Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Culpeper, Virginia   |  |
| 24 FUNERAL DIRECTOR<br>NAME Robert A. Pumphrey<br>ADDRESS Homes, P.A. Bethesda, Maryland  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 27 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey M. Brady</u>  |  |

UNITED STATES DEPARTMENT OF JUSTICE

JULY 22, 1933

U.S.A.

MEMORANDUM

TO : DIRECTOR

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

100-100000 - 100-100000 - 100-100000

[Illegible handwritten notes]

[Illegible handwritten notes]

[Illegible handwritten notes]

[Illegible handwritten notes]

RECEIVED JULY 22, 1933

100-100000 - 100-100000 - 100-100000

100-100000 - 100-100000 - 100-100000

100-100000 - 100-100000 - 100-100000



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |                                      |  |  |  |                                     |  |
|---|--|--|--|--|--|--------------------------------------|--|--|--|-------------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 20. DATE KNOWN OF DEATH                                  |  | 21. DATE OF DEATH  |  | 22. DATE OF DEATH                    |  | 23. DATE OF DEATH  |  | 24. DATE OF DEATH                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2. DATE KNOWN OF DEATH                                   |  | 21. DATE OF DEATH  |  | 22. DATE OF DEATH                    |  | 23. DATE OF DEATH  |  | 24. DATE OF DEATH                   |  |
| FIRST MIDDLE LAST   |  | MONTH DAY YEAR   |  | MONTH DAY YEAR   |  | MONTH DAY YEAR                       |  | MONTH DAY YEAR   |  | MONTH DAY YEAR                      |  |
| Rachel B. George  |  | 5 29 1980  |  | 5 29 1980  |  | 5 29 1980                            |  | 5 29 1980  |  | 5 29 1980                           |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)                    |  | 7. IF UNDER 24 HRS   |  | 8. DATE PRONOUNCED DEAD             |  |
| female  |  | white  |  | 2 18 97  |  | 83 YRS.                              |  | MONTHS DAYS HOURS MIN  |  | 5 29 1980                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 10. MARRIED  |  | 11. MARRIED                         |  |
| Virginia  |  | U.S.A.   |  | WIDOWED  |  | Montgomery                           |  | NEVER MARRIED  |  | DIVORCED                            |  |
| 12. CITY OR TOWN OF DEATH   |  | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 15. KIND OF BUSINESS OR INDUSTRY     |  | 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 17. USUAL RESIDENCE                 |  |
| Silver Spring   |  | Holy Cross Hospital                                      |  | Housewife  |  | Home                                 |  | Md.  |  | Md.                                 |  |
| 18a. STATE  |  | 18b. COUNTY  |  | 18c. CITY OR TOWN  |  | 18d. INSIDE CITY LIMITS?             |  | 18e. STREET ADDRESS  |  | 18f. STREET ADDRESS                 |  |
| Md.   |  | Montgomery   |  | Wheaton  |  | YES                                  |  | 11603 Galt Ave.  |  | 11603 Galt Ave.                     |  |
| 19. FATHER'S NAME   |  | 20. MOTHER'S MAIDEN NAME                                 |  | 21. INFORMANT  |  | 22. ADDRESS                          |  | 23. ADDRESS  |  | 24. ADDRESS                         |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST                    |  | FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST                   |  |
| Samuel John Bushey  |  | Alice Neil   |  | Dorothy G. Davis   |  | 11512 Galt Ave., Wheaton, Md. 20902  |  | 11512 Galt Ave., Wheaton, Md. 20902  |  | 11512 Galt Ave., Wheaton, Md. 20902 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT  |  | 22. ADDRESS                          |  | 23. ADDRESS  |  | 24. ADDRESS                         |  |
| No  |  | 578-54-9705T   |  | Dorothy G. Davis   |  | 11512 Galt Ave., Wheaton, Md. 20902  |  | 11512 Galt Ave., Wheaton, Md. 20902  |  | 11512 Galt Ave., Wheaton, Md. 20902 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 19. CAUSE OF DEATH                                       |  | 20. CAUSE OF DEATH   |  | 21. CAUSE OF DEATH                   |  | 22. CAUSE OF DEATH   |  | 23. CAUSE OF DEATH                  |  |
| PART I DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)                                      |  | DUE TO, OR AS A CONSEQUENCE OF                               |  | DUE TO, OR AS A CONSEQUENCE OF       |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF      |  |
| 4291  |  | Acute Myocardial Dis.                                    |  | Chronic Myocardial Dis.                                      |  | Chronic Myocardial Dis.              |  | Chronic Myocardial Dis.  |  | Chronic Myocardial Dis.             |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |  |  |  |  |                                      |  |  |  |                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  | None   |  | None   |  | None                                 |  | None   |  | None                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |  | 20. AUTOPSY?   |  | 21. AUTOPSY?                         |  | 22. AUTOPSY?   |  | 23. AUTOPSY?                        |  |
| None  |  | None   |  | YES  |  | NO                                   |  | YES  |  | NO                                  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21b. TIME OF INJURY                                      |  | 21c. HOW INJURY OCCURRED                                     |  | 21d. INJURY OCCURRED                 |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION                       |  |
| WHILE AT WORK   |  | HOUR A.M. MONTH DAY YEAR                                 |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2           |  | WHILE AT WORK                        |  | STREET, FACTORY, FARM, ETC.)   |  | CITY OR TOWN                        |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21b. TIME OF INJURY                                      |  | 21c. HOW INJURY OCCURRED                                     |  | 21d. INJURY OCCURRED                 |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION                       |  |
| WHILE AT WORK   |  | HOUR A.M. MONTH DAY YEAR                                 |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2           |  | WHILE AT WORK                        |  | STREET, FACTORY, FARM, ETC.)   |  | CITY OR TOWN                        |  |
| 22a. I certify that I took charge of the remains described above, held on   |  | Autopsy  |  | Inspection   |  | Inquiry                              |  | and in my opinion  |  | and in my opinion                   |  |
| death resulted from   |  | Natural causes   |  | Accident   |  | Suicide                              |  | Homicide   |  | Undetermined manner                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                           |  | 23d. LOCATION                        |  | 23e. COUNTY  |  | 23f. STATE                          |  |
| Burial  |  | June 2, 1980   |  | Cedar Hill Cemetery  |  | Suitland                             |  | P.G.   |  | Md.                                 |  |
| 24. FUNERAL DIRECTOR  |  | 25. DATE REC'D. BY REGISTRAR                             |  | 26. REGISTRAR'S SIGNATURE                                    |  | 27. REGISTRAR'S SIGNATURE            |  | 28. REGISTRAR'S SIGNATURE  |  | 29. REGISTRAR'S SIGNATURE           |  |
| NAME  |  | ADDRESS  |  | ADDRESS  |  | ADDRESS                              |  | ADDRESS  |  | ADDRESS                             |  |
| Hines/Rinaldi   |  | 11800 N.H. Ave.  |  | Silver Spring, Md.   |  | JUN 3 1980                           |  | JUN 3 1980   |  | JUN 3 1980                          |  |
| Funeral Home  |  | Silver Spring, Md.                                       |  | Silver Spring, Md.   |  | Silver Spring, Md.                   |  | Silver Spring, Md.   |  | Silver Spring, Md.                  |  |

BP

DHMH - 17  
TVR A15 ME (51)  
15M 7/76

3702





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |  |  | 8 0 1 3 2 6 2   |  |
|---|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>LENA</u> <u>GERBER</u>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>MAY 16</u> <u>80</u>                           |  | 2b. HOUR<br><u>10:45</u> <u>AM</u>                                |  |
| 3. SEX<br><u>Female</u>   | 4. RACE<br><u>White</u>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>March 4</u> , <u>1889</u>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>91</u> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Washington, D.C.</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Silver Spring</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Fairland Nursing Home</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Homemaker</u>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u>               |  |
| 13a. STATE<br><u>Maryland</u>   |   | 13b. COUNTY<br><u>Montgomery</u>  | 13c. CITY OR TOWN<br><u>Silver Spring</u>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS<br><u>2101 Fairland Road</u>                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Samuel</u> <u>---</u> <u>Oscar</u>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Rachael</u> <u>---</u> <u>Walker</u> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>   |   | 16b. SOCIAL SECURITY NO<br><u>579-14-6551</u>   |  | 17. INFORMANT<br>ADDRESS<br><u>Carole G. Early, 379 O. St., SW, Washington, DC</u>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u><br><u>4140</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DIS</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSIS</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>YEARS</u><br><u>YEARS</u> |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>---</u> <u>---</u> <u>19</u><br>P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>June 75</u> <u>May 16 80</u>   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>May 7 80</u> to <u>May 16 80</u> , that (I) (we) last saw the deceased alive on <u>May 7 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.)  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><u>Thos G. Ward</u>   |   | DEGREE<br><u>M.D.</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>5/16/80</u>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Thos G. Ward</u>  |   | 22e. ADDRESS<br><u>6116 ROBINWOOD, Bethesda, MD 20034</u>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |   | 23b. DATE<br><u>5/18/80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Wash. Heb. Cong. Mem. Pk.</u>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Washington, D.C.</u>  |
| 24. FUNERAL DIRECTOR: <u>Joseph Gawler's Sons, Inc.</u><br><u>5130 Wisconsin Ave., NW, Washington, D.C. 20016</u>   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 21 1980</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Robert A. Brady</u>   |

DEPT. OF SYAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |  |                      |   |  | 8 0 1 3 2 6 3                                   |  |
|--|--|---|--|---|---|--|----------------------|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | REG. NO.  |  |                      |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |   | 2a. DATE OF DEATH   |  |                      |   |  | 2b. HOUR  |  |
| FIRST MIDDLE LAST<br>Parthenia F. Gilbert  |  |   |  |   | MONTH DAY YEAR<br>May 16, 1980  |  |                      |   |  | 10:50 PM  |  |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                      | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS                                 |  |
| Female   |  | White   |  | MONTH DAY YEAR<br>Jan. 30, 1888   |   | 92 YRS.  |                      | MONTHS DAYS   |  | HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                      |   |  |   |  |
| Virginia   |  | U.S.A.  |  |   |   | Montgomery MD.   |                      |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                      | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |   |  |
| Bethesda   |  | 7500 Glenriddle Road  |  |   |   | Housewife  |                      | At Home   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13a. INSIDE CITY LIMITS?  |  | 13b. STREET ADDRESS  |   |  |   |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Montgomery Bethesda   |  |   |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 7500 Glenriddle Road |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ben Leake Sims   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Florence Ferneyhough |  |                      |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |   | 17. INFORMANT ADDRESS   |  |                      |   |  |   |  |
| No   |  |   | ---  |   | 577-22-2141D Louise G. Bulgher, Same as # 13.                         |  |                      |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY  |  |   |  |   |   |  |                      |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE   |  |   |  |   |   |  |                      |   |  | 2 YEARS   |  |
| 4269 DUE TO, OR AS A CONSEQUENCE OF<br>(b) HEART BLOCK WITH ELECTRONIC PACEMAKER   |  |   |  |   |   |  |                      |   |  | 13 YRS.   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) RENAL + RESPIRATORY FAILURE  |  |   |  |   |   |  |                      |   |  | 2 MONTHS  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |                      |   |  |   |  |
| LYMPHOBLASTIC LYMPHOMA (TREATED) 8 YRS.  |  |   |  |   |   |  |                      |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?  |                      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |   |  |
|  |  |   |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                      | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                      |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                      |   |  |   |  |
|  |  |   |  |   |   |  |                      |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965, 19 to MAY 16, 1980, that (I) (we) last saw the deceased alive on MAY 16, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |   |  |   |   |  |                      |   |  |   |  |
| 22b. SIGNATURE   |  |   |  |   | 22c. DATE SIGNED  |  |                      |   |  |   |  |
| Edward W. Youngblood, M.D.   |  |   |  |   | 5/17/80   |  |                      |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   | 22e. ADDRESS  |  |                      |   |  |   |  |
| Edward W. Youngblood   |  |   |  |   | 4900 Mass. Ave., NW, Washington, D.C.                                 |  |                      |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY                                    |  |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                        |  |   |  |
| Burial   |  |   | 5/19/80  |   | Cedar Hill Cemetery   |  |                      | Suitland, Maryland  |  |   |  |
| 24. FUNERAL DIRECTOR   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR  |                      | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| Joseph Walters Sons, Inc.<br>5130 Wisconsin Ave., NW, Washington, D.C. 20016   |  |   |  |   |   | MAY 21 1980  |                      | [Signature]   |  |   |  |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |   |  |  |   |  |
|--|--|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Jack B. Gildersleeve</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 17, 1980</b>                |   |   | 2b. HOUR<br><b>2:12am</b>  |  |   |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 22, 1932</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CONCERT PIANIST</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. CITY OR TOWN<br><b>MONTGOMERY</b>                                 |   | 13c. STREET ADDRESS<br><b>SILVER SPRING</b>                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br><b>BASTL</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>HARRIET ROBBINS</b>                     |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>unknown</b>   |  |  | 17. INFORMANT<br><b>SON</b>  |   |   | ADDRESS<br><b>903 N. BELGRADE RD SILVER SPRING, MD.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>hepatic failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute and chronic toxic hepatitis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pancreatic carcinoma</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                           |  |  |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Lanning R. Davidson</b>   |  |  | DEGREE<br><b>MD</b>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>18 May 80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lanning R. Davidson</b>  |  |  | 22e. ADDRESS<br><b>Mont. Gen Hosp</b>                                  |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>MAY 21, 1980</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WILLOW DALE CEMETERY</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BRADFORD McKEAN PA</b>                      |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b><br>ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Kelley</b>  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |  |                              |  |   | 8 0 1 3 2 6 5 |  |
|--|--|---|--|--|---|--|------------------------------|--|---|---------------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |  |   |  |                              |  |   |               |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Wilson P Gill   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 20 1980               |  |                              | 2b. HOUR<br>9 PM   |   |               |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>10 19 15   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  |                              | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><del>XXXXXXXXXXXX</del> Montgomery MD.  |                              |  |   |               |  |
| 10 CITY OR TOWN OF DEATH<br>Takoma Park  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sligo Garden Nursing Home |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Paint Store   |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br>Jones   |   |               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |   |  |  | 13b. COUNTY<br>Montgomery                                     |  | 13c. CITY OR TOWN<br>Bl. Sp. |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George R. Gill  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary A. Padgett |  |                              |  |   |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>none  |  | 17 INFORMANT (wife)<br>Margaret C. Gill-(same as 13e)  |   | ADDRESS  |                              |  |   |               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Probable asphyxia food aspiration.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Organic Brain Syndrome.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |   |  |  |   |  |                              |  |   |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |   |  |                              |  |   |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                              |  |   |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |                              |  |   |               |  |
| 22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>4/14/1980</u> to <u>5-20-1980</u> , that (1) <u>last</u> I saw the deceased alive on <u>5-4-80</u> 19 <u>80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>see</u> (did) <u>dissect</u> <u>view</u> the body after death. |  |   |  |  |   |  |                              |  |   |               |  |
| 22b. SIGNATURE<br><u>Dr. Smith Ho</u>  |  |   |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                              | 22c. DATE SIGNED<br>5-20-80  |   |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Smith Ho  |  |   |  | 22e. ADDRESS<br>8323 Haddon Dr. TK PK md 20012   |   |  |                              |  |   |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>5-21-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory Alex. Fairfax   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Va.   |                              |  |   |               |  |
| 24. FUNERAL DIRECTOR<br>Walter B. Pumphrey, Inc.<br>8434 Ga. Ave., S.S. Md.  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>MAY 22 1980  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Clark E. Wisner</u>   |                              |  |   |               |  |

DATE: JAN 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |   |  |   |  |                         | 8 0 1 3 2 6 6   |  |
|--|--|---|--|--|---|--|---|--|-------------------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | CERTIFICATE OF DEATH  |  |  |   |  |   |  |                         | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET MARCELLA GOGGIO</b>  |  |   |  |  | 2a. DATE OF DEATH   |  | MONTH <b>5</b> DAY <b>27</b> YEAR <b>1980</b>   |  | 2b. HOUR <b>7:15 PM</b> |   |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>23</b> YEAR <b>1924</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS                                       |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |                         | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                          |   |  |                         |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROCKVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>14003 BAUER DRIVE</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                         |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>14003 BAUER DRIVE</b> |  |                         |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>ROCKVILLE</b>  |   |  |   |  |                         |   |  |
| 14. FATHER'S NAME<br>FIRST <b>IGNATIUS</b> MIDDLE <b>COLUMBUS</b> LAST <b>COLUMBUS</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNA</b> MIDDLE <b>KLINK</b> LAST <b>KLINK</b>             |  |   |  |                         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>176-20-9320</b>  |  | 17. INFORMANT<br><b>DONALD J. GOGGIO</b>   |   | ADDRESS<br><b>SAME AS 13 HUSBAND</b>   |   |  |                         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>Cancer, Source Unknown, with metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |   |  |   |  |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |   |  |   |  |                         |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                         |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |                         |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |                         |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>5-26</b> , 19 <b>80</b> , to <b>5-27</b> , 19 <b>80</b> , that (1) (we) last saw the deceased alive on <b>5-26</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.                                |  |   |  |  |   |  |   |  |                         |   |  |
| 22b. SIGNATURE<br><i>Morris Perry</i>  |  |   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |   | 22c. DATE SIGNED<br><b>5-27-80</b>   |                         |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Morris Perry M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>SILVER SPRING, MARYLAND</b>   |   |  |   |  |                         |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/31/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. CATHERINES CEMETERY</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>LEECHBURG</b> COUNTY <b>ARMSTRONG</b> STATE <b>PA</b> |   |  |                         |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1980</b>                                    |   | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony Kelly</i>   |                         |   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |  |                                   |  |  |
|--|--|--|--|---|---|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 8 0 1 3 2 6 7   |  |                                   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |   | 2a. DATE OF DEATH   |  |                                   |  |  |
| Johanna Goldstein  |  |  |  |   | 5 13 80 3 <sup>10</sup> AM  |  |                                   |  |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH   |   | 6 AGE (IN YEARS LAST BIRTHDAY)   |                                   | 7b. HOUR   |  |
| female   |  | Caucasian  |  | Jan. 25, 1904   |   | 76 YRS.  |                                   | 3 <sup>10</sup> AM   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |  |  |
| Germany  |  | U.S.A.   |  |   |   | Montgomery MD  |                                   |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Bethesda   |  | Suburban Hospital  |  |   |   | Housewife  |                                   | Own Home   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?  |  |                                   |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |  |  |  |   | 13e. STREET ADDRESS   |  |                                   |  |  |
| Maryland Montgomery Bethesda   |  |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 4890 Battery Lane |  |                                   |  |  |
| 14 FATHER'S NAME   |  |  |  |   | 15. MOTHER'S MAIDEN NAME  |  |                                   |  |  |
| FIRST MIDDLE LAST  |  |  |  |   | FIRST MIDDLE LAST   |  |                                   |  |  |
| Ball   |  |  |  |   | Unknown   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT  |   | ADDRESS  |                                   |  |  |
| No   |  | 577-24-5634  |  | Mr Alan Feld  |   | 7427 Arlington Rd Bethesda, Md.  |                                   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u>  |  |  |  |   |   |  |                                   |  |  |
| 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarct</u>  |  |  |  |   |   |  |                                   | 8 hrs.   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  |  |  |   |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |   |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY                              |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR                         |   |   |  |                                   |  |  |
|  |  |  | P.M. 19  |   |   |  |                                   |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY                             |   |   | 21f. LOCATION  |                                   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | STREET CITY OR TOWN COUNTY STATE   |                                   |  |  |
| 22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>May 1</u> 19 <u>80</u> , to <u>May 13</u> 19 <u>80</u> , that <u>he</u> (we) lost <u>saw</u> the deceased alive on <u>May 13</u> 19 <u>80</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> (did not) view the body after death. |  |  |  |   |   |  |                                   |  |  |
| 22b. SIGNATURE   |  |  |  |   | DEGREE  |  | 22c. DATE SIGNED                  |  |  |
| MARVIN WADLER  |  |  |  |   | M.D.  |  | 5/13/80                           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   | 22e. ADDRESS  |  |                                   |  |  |
| MARVIN WADLER  |  |  |  |   | 8218 Wisc Av. Beth., Md.  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION                     |  |  |
| Burial   |  |  | 5-15-80  |   | Washington Heb. Cem   |  | Washington D.C.                   |  |  |
| 24 FUNERAL DIRECTOR NAME   |  |  |  |   | ADDRESS   |  | MAY 26 1980 REGISTRAR'S SIGNATURE |  |  |
| DANZANSKY-GOLDBERG   |  |  |  |   | CHAPELS   |  | ROCKVILLE MD.                     |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 2 6 8

REG. NO.

|  |  |   |  |   |  |  |   |   |   |  |  |
|--|--|---|--|---|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FLORENCE A GOODACRE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-1-80</b>                   |   |  | 2b. HOUR<br><b>4:50</b> M  |   |   |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 20 1888</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.                                      |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>                   |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOSTLY WORKING LIFE)<br><b>Proof reader</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Newspaper</b>   |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Montgomery</b>                                       |   | 13c. CITY OR TOWN<br><b>Sil. Spring</b>                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>312 Wayne Avenue,</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Narcisse Grenier</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Adele Tardiffe</b>  |  |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>none</b> |   | 17. INFORMANT<br><b>Norman Goodacre-son- (same as 13e)</b>           |  | ADDRESS   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHF</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b> |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5-1-80</b>   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>sp. Carcinoma @ kidney, Probable kidney carcinoma metastatic to liver, UTI</b>  |  |   |  |   |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>None</b>  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |   |   |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>2-14-80</b> , 19____, to <b>5-1-80</b> , 19____, that (1) (the) last saw the deceased alive on <b>5-1-80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                  |  |   |  |   |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>MB Patrick MD</b>   |  |   |  |   | DEGREE   |  |   | 22c. DATE SIGNED<br><b>5-1-80</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G B Patrick MD</b>   |  |   |  |   | 22e. ADDRESS<br><b>9221 Colesville Rd<br/>Silver Spring Md 20910</b> |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>5-5-1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln</b>            |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Georges Md.</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Warner E. Pumphrey, INC, 8434 Ga. Ave.<br/>S.S. Md.</b>   |  |   |  |   |  |  |   |   |   |  |  |



CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

Dr. Ball gave permission for kidney donation

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                         |  |   |  |   |  |   |  | 8 0 1 3 2 6 9  |  |   |  |   |  |   |  |
|---|--|-------------------------|--|---|--|---|--|---|--|--|--|---|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |  |   |  |   |  | REG. NO.   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALAN B. GRAHAM</b>   |  |                         |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5-11-1980</b> |  | 2b. HOUR<br><b>7:45 PM</b>                                  |  |   |  |   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Aug. 30, 1954</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>27</b> YRS.   |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>5-11-1980</b>  |  | 2d. HOUR<br><b>7:45 PM</b>                                  |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pittsburgh, Pa.</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |  |   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cab driver</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Diamond Cab Co.</b> |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         |  |   |  |   |  |   |  | 13b. COUNTY<br><b>Frederick</b>  |  | 13c. CITY OR TOWN<br><b>Urbana</b>                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Route #2 Box #447</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alvan Phillips Graham</b>  |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Roberta - Johnston</b>  |  |   |  |  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>225-78-6561</b>  |  | 17. INFORMANT<br>ADDRESS <b>Alexandria, Va. 22311</b><br><b>Margaret H. King (Sister) 803-So. Fairfax St.</b>                   |  |   |  |  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Caraberal Trauma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Auto. Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |                         |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  |   |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2:25 am 5-11-1980</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>in Parked car struck - in Rear by Van -</b> |  |   |  |  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Highway</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>E 270 - Montrose Rd Rockville Mont. Md.</b>                             |  |   |  |  |  |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .                                       |  |                         |  |   |  |   |  |   |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>   |  |                         |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  |   |  | DATE SIGNED<br><b>May 11, 1980</b>  |  |  |  |   |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John G. Ball, MD</b>   |  |                         |  | ADDRESS<br><b>Bethesda, Maryland</b>  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |                         |  | 23b. DATE<br><b>5-13-1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>                                    |  |   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., D.C.</b>   |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |   |  |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

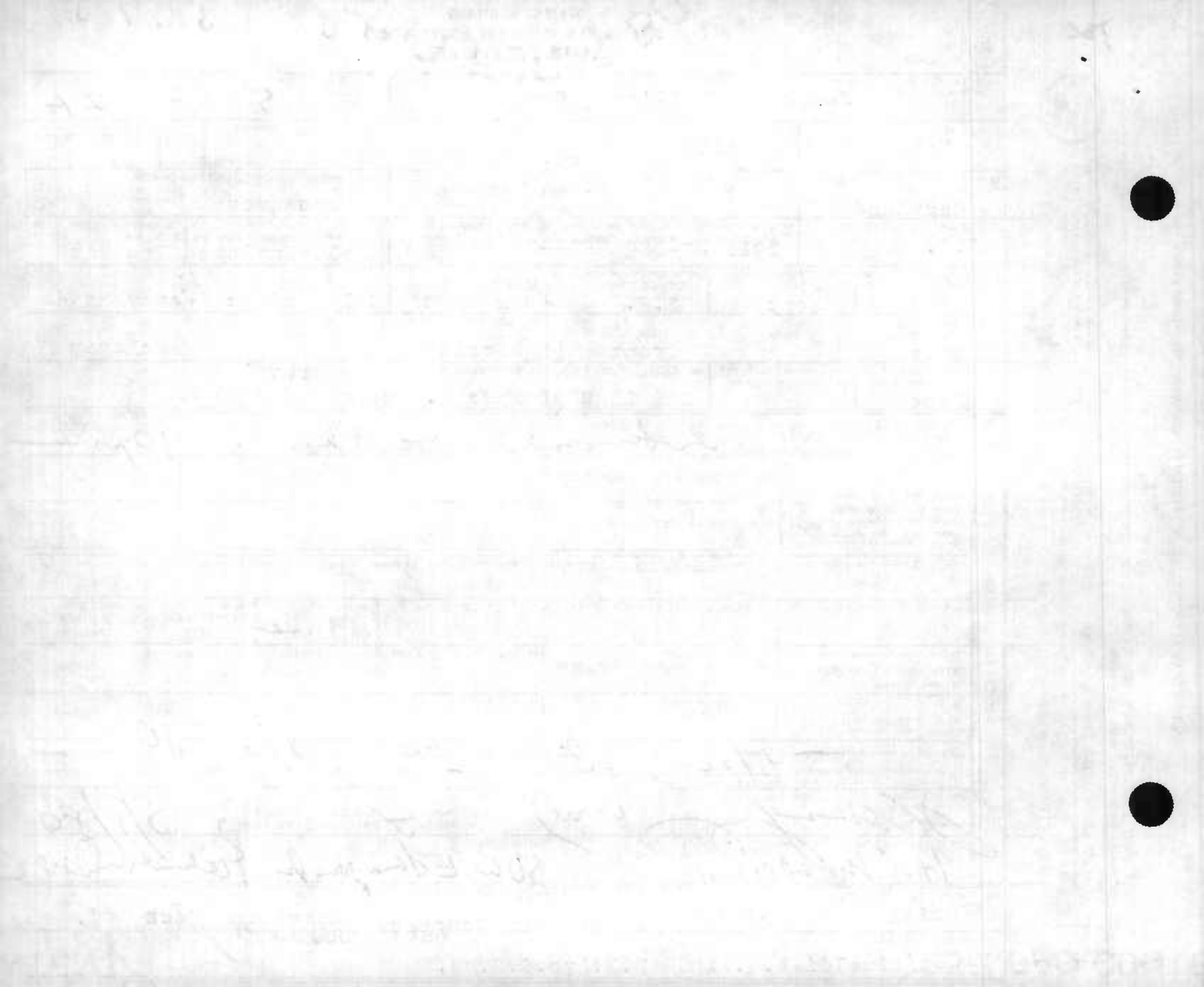
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James William Grant  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 5 1980                                 |  | 2b. HOUR<br>2 A M  |
| 3 SEX<br>Male   | 4 RACE<br>White  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 12, 1923   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                            |  |  |
| 10 CITY OR TOWN OF DEATH<br>S.S.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2015 Briggs Chaney Road |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self-Employed | 12b. KIND OF BUSINESS OR INDUSTRY<br>Trucker   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md   |  |  | 13b. COUNTY<br>Mont   | 13c. CITY OR TOWN<br>S.S.  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Grant  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie McKevey                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>None  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216 12 0332   | 17 INFORMANT (Same as above)<br>2 Anna E. Grant (Wife)                            |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Arterioventricular Heart Disease</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 yrs +   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>6/2/80</u> to <u>5/5/80</u> , that (I) (we) last saw the deceased alive on <u>9/2/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  | DEGREE<br><u>MD</u>  |   | 22c. DATE SIGNED<br><u>5/5/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>H.C. McGee</u>  |  | 22e. ADDRESS<br><u>SD W. E. Thompson Dr. Rockville Md.</u>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br>Burial   | 23b. DATE<br>5/7/80  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rockville Montgomery Md.               |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Hines/Rinaldi  |  | 24b. ADDRESS<br>F.H. 11800 N.H. Ave. S.S. Md.  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8013271  |  |   |  |   |                              |
|--|--|---|--|---|--|---|--|---|------------------------------|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  | 2b. HOUR  |                              |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Pearl B. GRAY   |  |   |  | May 13 1980   |  |   |  | 2:10P M   |                              |
| 3 SEX<br>Female  |  | 4 RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 5 1925  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.  |  | # UNDER 1 YEAR<br>MONTHS DAYS   | # UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |   |                              |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                      |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY<br>Virginia Fairfax  |  |   |  | 13c. CITY OR TOWN<br>Annandale  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4579 Airlie Way  |                              |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>John Brewer  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lydia Brewer   |  |   |  |   |                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO<br>244 32 0447  |  | 17 INFORMANT ADDRESS<br>Robert A. Gray See item 13  |  |   |  |   |                              |
| 18 CAUSE OF DEATH (Enter only one cause - 4 lines for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 431- Intracerebral bleed complicating right middle cerebral artery aneurysm<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____               |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |                              |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |   |                              |
| 22a. I certify that I (this hospital) attended the deceased from Apr. 29 1980, to May 13 1980, that I (we) last saw the deceased alive on May 13 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) |  |   |  |   |  |   |  |   |                              |
| 22b. SIGNATURE<br>Michael W. Meriwether MD   |  |   |  | 22c. DATE SIGNED<br>May 14, 1980  |  |   |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                              |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael W. Meriwether, M.D.   |  |   |  | 22f. ADDRESS<br>National Naval Medical Center, Bethesda, Md.  |  |   |  |   |                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>May 16, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Arlington Arlington Va.                              |  |   |                              |
| 24 FUNERAL DIRECTOR NAME<br>Murphy Arlington Funeral Home, Arlington, Va.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 19 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |                              |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |   |  |   |                                 |
|--|--|---|---|---|--|---|--|---|---------------------------------|
| 1. FOR STATE REGISTRAR   |  |   |   |   | 8013272  |   |  |   |                                 |
| 1. DECEASED NAME (TYPE OR PRINT) <b>HYMAN GREEN</b>  |  |   |   |   | 2a. DATE OF DEATH MONTH <b>MAY</b> DAY <b>15</b> YEAR <b>1980</b>                    |   |  | 2b. HOUR <b>9:45 A.M.</b>   |                                 |
| 3 SEX <b>MALE</b>  |  | 4 RACE <b>WHITE</b>   |   | 5 DATE OF BIRTH MONTH <b>NOV.</b> DAY <b>27</b> YEAR <b>1911</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>                               |                                 |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASSACHUSETTS</b>  |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.   |  |   |                                 |
| 10 CITY OR TOWN OF DEATH <b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FURNITURE STORE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>OWNER</b>   |   |                                 |
| 13a. STATE <b>MASSACHUSETTS</b>  |  | 13b. COUNTY <b>MALDEN</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13c. STREET ADDRESS <b>40 SPRING STREET</b>   |  |   |                                 |
| 14. FATHER'S NAME FIRST <b>ROBERT</b> MIDDLE <b></b> LAST <b>GREEN</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST <b>POLLIE</b> MIDDLE <b></b> LAST <b>LEVINE</b>  |  |   |  |   |                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>030-07-7771</b>  |   | 17 INFORMANT <b>EDWARD GREEN, 720 PRINCETON PLACE, ROCKVILLE, MARYLAND</b>  |  |   |  |   |                                 |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>intermediate</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  |                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |   |  |   |                                 |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                        |  |   |                                 |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12 May</b> 19 <b>80</b> to <b>15 May</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>14 May</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |   |   |  |   |  |   |                                 |
| 22b. SIGNATURE <b>Horace Bernton for F.A. Gier, M.D.</b>   |  |   |   |   | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED <b>5/17/80</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. HORACE BERNTON, m.d.</b>  |  |   |   |   | 22e. ADDRESS <b>4743 BRADLEY BOULEVARD, CHEVY CHASE, MD.</b>                         |   |  |   |                                 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>5/18/1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>WORKMEN'S CIRCLE CEMETERY</b>   |  | 23d. LOCATION CITY OR TOWN <b>WEST ROXBURY</b> COUNTY <b>MASSACHUSETTS</b> STATE <b>MASSACHUSETTS</b> |  |   |                                 |
| 24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>   |  |   |   |   | 24a. DATE RECEIVED BY REGISTRAR <b>MAY 19 1980</b>                                   |   | 24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |   |                                 |
| 25. ADDRESS <b>232 CARROLL STREET, N.W., WASHINGTON, D.C.</b>  |  |   |   |   |  |   |  |   |                                 |



NO. 120-47-7771 EDWARD GREEN, DOCKVILLE, MASSACHUSETTS  
 780 PLYMOUTH BLVD. LEVINE  
 GREEN PAULIE  
 40 SPRING STREET  
 MASSACHUSETTS WALTER  
 8  
 FURNITURE STORE OWNER  
 MOUNTAIN  
 U.S.A.  
 WHITE  
 MAY 1900

2/18/1980 MORRISON'S CIRCLE CEMETERY WEST ROXBURY, MASSACHUSETTS  
 DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME INC.  
 831 CARROLL STREET, N.W., WASHINGTON, D.C.  
 ST. HORACE REYNOLDS, N.Y. 1745 STAPLEY BOULEVARD, CHEVY CHASE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |  |   | REG. NO. 80 13273  |                                   |   |  |
|---|---|--|---|--|-----------------------------------|---|--|
| 1. FOR STATE REGISTRAR  |   | 1. DECEASED NAME (TYPE OR PRINT) <u>TRANSIT LASHELLE GREENE (WILLIAMS)</u>   |   | 2a. DATE OF DEATH MONTH <u>5</u> DAY <u>21</u> YEAR <u>80</u>  |                                   | 2b. HOUR <u>9<sup>00</sup> AM</u>   |  |
| 3. SEX <u>Female</u>  | 4. RACE <u>BLK</u>  | 5. DATE OF BIRTH MONTH <u>5</u> DAY <u>21</u> YEAR <u>80</u>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <u>5</u> YRS. MONTHS <u>5</u> DAYS <u>26</u>   |                                   | IF UNDER 1 YEAR IF UNDER 24 HRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>   | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH <u>Silver Spring</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>NONE</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <u>MD</u> 13c. COUNTY <u>Prince Geo</u>   | 13d. CITY OR TOWN <u>Upper Marlboro</u>   | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  | 13f. STREET ADDRESS <u>117 Swiss Gap</u>                                  |  |                                   |   |  |
| 14. FATHER'S NAME FIRST <u>TOMMIE</u> MIDDLE <u>LEE</u> LAST <u>WILLIAMS</u>  |   | 15. MOTHER'S MAIDEN NAME FIRST <u>JACQUELINE</u> MIDDLE <u>M.</u> LAST <u>GREENE</u>   |   |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>   |   | 16b. SOCIAL SECURITY NO <u>NONE</u>  |   | 17. INFORMANT ADDRESS <u>UPPER MARLBORO, MD</u><br><u>JACQUELINE GREENE 117 SWISS GAP</u>  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u>  |   |  |   |  |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 7651  |   |  |   |  |                                   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____  |   |  |   |  |                                   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |   |  |   |  |                                   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |   |  |                                   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>May 21, 1980</u> to <u>May 21, 1980</u> , that (I) (we) saw the deceased alive on <u>May 21, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |   |  |                                   |   |  |
| 22b. SIGNATURE <u>Stanley H. Steinberg, M.D.</u>  |   | DEGREE <u>M.D.</u>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED <u>5/21/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STANLEY H. STEINBERG, M.D.</u>   |   | 22e. ADDRESS <u>831 UNIV. BLVD. E. SEC. 176, MD. 20903</u>   |   |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>   |   | 23b. DATE <u>5-24-80</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Lindem Cemetery</u>  |                                   | 23d. LOCATION CITY OR TOWN <u>Spartanburg</u> COUNTY <u>MD</u> STATE  |  |
| 24. FUNERAL DIRECTOR NAME <u>Johnson &amp; Jenkins</u>  |   | ADDRESS <u>716 Kennedy St. NW 20011</u>  |   | 25. DATE REC'D. BY REGISTRAR <u>JUN 3 1980</u>   |                                   | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|   |  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|--|---|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <i>Charles Vivian Grimes</i>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>5-30-80</i>                     |  | 2b. HOUR<br><i>3:45 AM</i>                                |  |   |  |  |  |
| 3 SEX<br><i>male</i>  |  | 4 RACE<br><i>white</i>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Dec. 27 1904</i>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><i>75</i>                           |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br><i>IF UNDER 24 HRS<br/>HOURS MIN</i>   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                             |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>Takoma Park</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist</i> |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Movie Theaters</i> |   | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><i>Maryland</i>   |  |  | 13b COUNTY<br><i>Montgomery</i>  |  | 13c CITY OR TOWN<br><i>Olney</i>                          |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><i>3234 Spartan Road Apt. 74</i> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Thomas William Grimes</i>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Annie Lee</i>       |  |   |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  |  | 16b SOCIAL SECURITY NO.<br><i>577-10-0848</i>                          |  | 17 INFORMANT<br><i>wife</i>                               |  | ADDRESS<br><i>same as 13</i>  |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i><br><i>493-</i> DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>10 years</i> |  |  |  |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |  |   |  |  |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>      |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>APRIL 1972</i> to <i>MAY 30 1980</i> , that (I) <i>last</i> saw the deceased alive on <i>MAY 29 1980</i> , and that in (my) <i>(own)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>was not</i> (did not) view the body after death.  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Seruch T. Kimble MD</i>  |  |  |  |  |   | DEGREE<br><i>MD</i>  |   | 22c. DATE SIGNED<br><i>5-30-80</i>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Seruch T. Kimble</i>  |  |  |  |  |   | 22e. ADDRESS<br><i>980, GEORGIA AVE, SILVER SPRING, MD</i>                               |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>Jun 2 1980</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Fort Lincoln</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Brentwood Pr. Geo. Md.</i>         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Francis J. Collins</i> ADDRESS <i>500 University Blvd., W. Silver Spring, Md.</i>   |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 3 1980</i>                                       |   | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

52

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR 15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |  |                   |   |                     |                                    |  |                                    |  |  |  |
|---|---------|--|-------------------|---|---------------------|------------------------------------|--|------------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR  |         | 20. DATE KNOWN OF DEATH                                  |                   | 21. MONTH   |                     | 22. DAY                            |  | 23. YEAR                           |  | 24. HOUR                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |         | 20. DATE KNOWN OF DEATH                                  |                   | 21. MONTH   |                     | 22. DAY                            |  | 23. YEAR                           |  | 24. HOUR                                     |  |
| George Richard Grove  |         | 5/27   |                   | 19  |                     | 80                                 |  |                                    |  | P. M.  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR.   | 8. IF UNDER 24 HRS. | 20. DATE PRONOUNCED DEAD           |  | 21. MONTH                          |  | 22. DAY                                      |  |
| Male  | White   | Jan 4, 1925  | 35 YRS.           |   |                     | 5/27                               |  | 19                                 |  | 80   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                             |                   | 8. MARRIED  |                     | 9. NEVER MARRIED                   |  | 10. DIVORCED                       |  | 11. BALTIMORE CITY OR COUNTY OF DEATH        |  |
| Ohio  |         | USA  |                   | WIDOWED   |                     | NEVER MARRIED                      |  | DIVORCED                           |  | Montgomery County MD.                        |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                     | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                    |  |  |  |
| Rockville   |         | 5014 Barkwood Place                                      |                   | Scientist   |                     | Science                            |  |                                    |  |  |  |
| 13a. STATE  |         | 13b. COUNTY  |                   | 13c. CITY OR TOWN   |                     | 13d. INSIDE CITY LIMITS?           |  | 13e. STREET ADDRESS                |  |  |  |
| Maryland  |         | Montgomery   |                   | Rockville   |                     | YES                                |  | 5014 Barkwood Place                |  |  |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME                                 |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                  |                     | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT                      |  | ADDRESS                                      |  |
| Allen H. Grove  |         | Elva Cordray   |                   | no  |                     | 289-18-9825                        |  | Dorothy M. Grove-wife-             |  | (same as 13e)                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | 19. IMMEDIATE CAUSE (a)                                  |                   | 20. DUE TO, OR AS A CONSEQUENCE OF                            |                     | 21. DUE TO, OR AS A CONSEQUENCE OF |  | 22. DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 1629  |         | Carcinoma of the lung (small cell).                      |                   |   |                     |                                    |  |                                    |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         | None   |                   |   |                     |                                    |  |                                    |  |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |                   | 20. AUTOPSY?  |                     |                                    |  |                                    |  |  |  |
| None  |         |  |                   | YES   |                     | NO                                 |  |                                    |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |         | 21b. TIME OF INJURY                                      |                   | 21c. HOW INJURY OCCURRED                                      |                     | 21d. INJURY OCCURRED               |  | 21e. PLACE OF INJURY               |  | 21f. LOCATION                                |  |
|   |         | HOUR A.M. MONTH DAY YEAR                                 |                   | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2            |                     | WHILE AT WORK                      |  | STREET, FACTORY, FARM, ETC.)       |  | CITY OR TOWN                                 |  |
|   |         | P.M. 19  |                   | None  |                     |                                    |  |                                    |  | COUNTY                                       |  |
|   |         |  |                   |   |                     |                                    |  |                                    |  | STATE  |  |
| 22a. I certify that I took charge of the remains described above, held on   |         | Autopsy  |                   | Inspection  |                     | Inquiry                            |  | and in my opinion                  |  |  |  |
| death resulted from:  |         | Natural causes   |                   | Accident  |                     | Suicide                            |  | Homicide                           |  | Undetermined manner                          |  |
|   |         | X  |                   |   |                     |                                    |  |                                    |  |  |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)  |                   | DATE SIGNED   |                     |                                    |  |                                    |  |  |  |
| John S. Rogers, M.D.  |         | Deputy   |                   | 5/28/79   |                     |                                    |  |                                    |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS  |                   |   |                     |                                    |  |                                    |  |  |  |
| John S. Rogers, M.D.  |         | 1919 Seminary Road                                       |                   |   |                     |                                    |  |                                    |  |  |  |
|   |         | Silver Spring, Montgomery, Md.                           |                   |   |                     |                                    |  |                                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY                            |                     | 23d. LOCATION                      |  | 23e. COUNTY                        |  | 23f. STATE                                   |  |
| Burial  |         | 5-31-1980  |                   | Concord Cemetery  |                     | Ashville Franklin                  |  | Ohio                               |  |  |  |
| 24. FUNERAL DIRECTOR'S NAME   |         | 25. REGISTRAR'S SIGNATURE                                |                   |   |                     |                                    |  |                                    |  |  |  |
| Warner E. Pumphrey, Inc.  |         | [Signature]  |                   |   |                     |                                    |  |                                    |  |  |  |
| 8434 Ga. Ave., S.S. MD  |         |  |                   |   |                     |                                    |  |                                    |  |  |  |

BP



Chas. E. Wilson

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |  |  |   |  |  |  |
|--|--|---|---|--|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Carl A Gustafson</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-21-80</b>                              |  |  | 2b HOUR<br>M  |  |  |  |
| 3 SEX<br><b>M</b>  |  | 4 RACE<br><b>W</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 8 94</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                      |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>trimmer</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>hat factory</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |  |  |   |  |  |  |
| 13a STATE<br><b>MD</b>   |  | 13b CITY OR TOWN<br><b>Laurel</b>   |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>6000 Parkway Drive</b>                                   |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Claus Gustafson</b>  |  |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>    |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>NW 1 044 05 2856</b> |  | 17. INFORMANT<br>ADDRESS<br><b>Carl E. Gustafson same as above</b> |   |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF PROSTATE GLAND</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>16 MOS</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>STAPH AUREUS PNEUMONIA; E. COLI URINARY TRACT INFECTION</b>  |  |   |   |  |  |   |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>SEPT 24</b> , 19 <b>79</b> , to <b>MAY 21</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>MAY 21</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |   |   |  |  |   |  |  |  |
| 22b SIGNATURE<br><b>James G. Brown</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br><b>5/22/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES A. BROWN MD</b>  |  |   |   | 22e ADDRESS<br><b>6525 BELMONT RD<br/>HYATTSVILLE MD 20782</b>   |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>May 24, 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wooster Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Danbury, Connecticut</b>         |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Donaldson Funeral Home, Laurel, Maryland</b>   |  |   |   | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 2 1980</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>Jeffrey McBrady</b>                               |  |  |  |

MEDICAL CERTIFICATION



TD HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8013277   |  |                              |  |
|---|--|---|--|--|--|--|--|--|--|------------------------------|--|
| 1 DECEASED NAME (TYPE OR PRINT)<br>Florence HAGERDON  |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>May 13 1980   |  |  |  | 2b HOUR<br>1052P M   |  |                              |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Caucasian   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>May 31 1905  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  | 7 IF UNDER 1 YEAR MONTHS DAYS  |  | 8 IF UNDER 24 HRS HOURS MIN. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |  |  |                              |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                      |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Home   |  |                              |  |
| 13a STATE<br>Virginia   |  | 13b COUNTY<br>Fairfax   |  | 13c CITY OR TOWN<br>McLean   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>6251 Old Dominion Drive  |  |                              |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>William nmi Heffner   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST LAST<br>Mayme nmi Snyder   |  |  |  |  |  |                              |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b SOCIAL SECURITY NO.<br>247 78 5074   |  | 17 INFORMANT ADDRESS<br>Mrs. Joan Kern, Box 432A R.D. 1, Center/Valley, Pa.                    |  |  |  |                              |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction<br>410 -<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |  |  |                              |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                              |  |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |                              |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from May 13, 1980, to May 13, 1980, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |  |  |                              |  |
| 22b SIGNATURE<br>Krogh  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |  |  | 22c DATE SIGNED<br>May 15, 1980  |  |                              |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Krogh, M.D.   |  |   |  | 22e ADDRESS<br>National Naval Medical Center, Bethesda, Md.  |  |  |  |  |  |                              |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b DATE<br>5/17/80   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Memorial Park Allentown  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Lehigh PA  |  |  |  |                              |  |
| 24 FUNERAL DIRECTOR NAME<br>Tyson Wheeler Funeral Home, Rockville, Md.  |  |   |  | 24b ADDRESS  |  | 25a DATE REC'D. BY REGISTRAR<br>MAY 19 1980  |  | 25b REGISTRAR'S SIGNATURE  |  |                              |  |



Home

1941

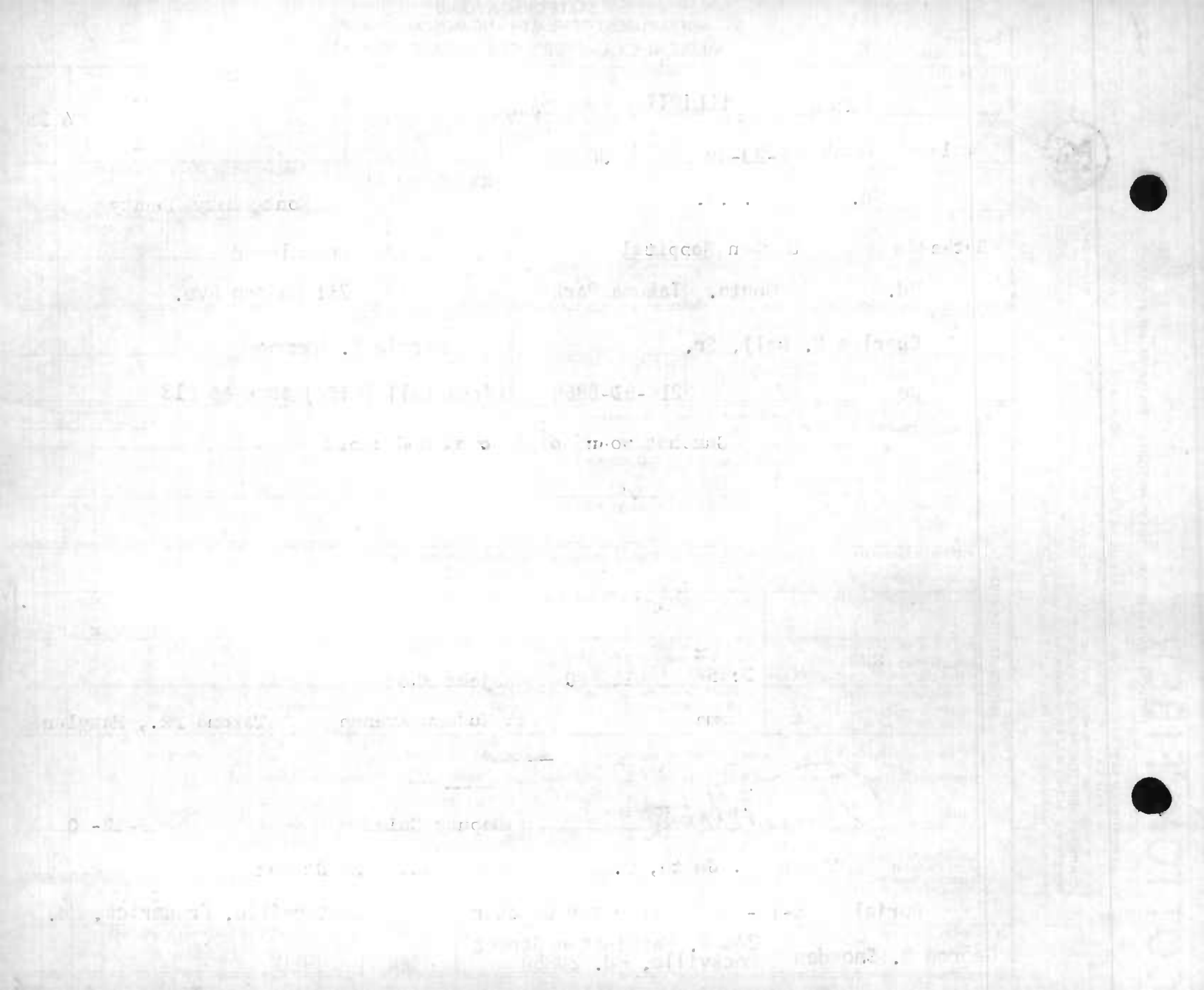
1941

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. RETURN TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |  |   |  |   |  | REG. NO. 8013278  |  |  |  |
|---|--|-------------------------|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GORDON ELLIOTT HALL</b>   |  |                         |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>5 11 1980</b>                       |  | 2b. HOUR<br><b>4:30 P M</b>  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-23-49</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>30 YRS.</b>                      |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN<br><b>0 0 0 0</b>  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>5 11 1980</b>                      |  | 4c. 30 P M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Surban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |
| 13a. STATE<br><b>Md.</b>  |  |                         |  | 13b. COUNTY<br><b>Montg.</b>   |  |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 13d. STREET ADDRESS<br><b>711 Hudson Ave.</b>                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles N. Hall, Sr.</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margie V. Hammond</b> |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>216-50-6869</b>   |  |   |  | 17. INFORMANT ADDRESS<br><b>Linda Hall (wife) same as #13</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of abdomen and chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                         |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                         |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3:15 P.M. 5 11 1980</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject shot</b>  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>711 Hudson Avenue Takoma Pk., Maryland</b>  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |  |                         |  | TITLE (SPECIFY)<br><b>M.D. Deputy Chief</b>  |  |   |  | DATE SIGNED<br><b>5-12-80</b>   |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>   |  |                         |  | ADDRESS<br><b>111 Penn Street</b>  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>5-16-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ebenezer Cemetery</b>            |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Centerville, Frederick, Md.</b>    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George R. Snowden</b>  |  |                         |  | 24b. ADDRESS<br><b>246 W. Washington Street Rockville, Md. 20850</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 19 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>                                |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 may be retained by the hospital or attending physician.

1

# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

13279

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Mary E Hall</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>May</b> Day <b>5</b> Year <b>1980</b>   |   |  | 2b. HOUR<br>M   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>Sept 4, 1907</b>   |  | 6. AGE (In years last birthday)<br><b>72</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Kensington,</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>10310 Detrick Ave</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Ret. Librarian, Mont. Co.</b>                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Libraries</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission). STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |   | 13c. CITY OR TOWN<br><b>Kensington</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>13e. STREET AND NUMBER<br><b>10310 Detrick Ave.</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Casper G. Dickson</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Hattie S. Hodges</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>579-05-1490</b>   |   | 17. INFORMANT<br><b>Kensington, Md. Richard C. Hall-husband 10310 Detrick Ave</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer pulmonary arrest</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma of the breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>77</b> , to <b>April 30</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>April 30</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Peter A. Moskovitz, M.D.</b>   |  |  |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>May 5, 1980</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Peter A. Moskovitz, M.D.</b>   |  | 22e. ADDRESS<br><b>2520 L Street, NW Washington, D.C.</b>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |  | 23b. DATE<br><b>May 6 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>J. William Lee's Sons Co.</b>  |  |  |   | ADDRESS<br><b>300 4th, St. N.E. Washington, D.C. 20002</b>  |  | 25a. REC'D BY REGISTRAR<br><b>MAY 8 1980</b>  |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>   |  |   |  |



COLLON 1156

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |   |   |   |                         |   |  |
|---|--|---|---|---|-------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   | MIDDLE  | LAST  | 2a. DATE KNOWN OF DEATH |   | 2b. HOUR                                     |
| Mary N. Hall  |  |   |   |   | DATE KNOWN OF DEATH     | ESTIMATED   | 245 M  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | IF UNDER 1 YR.  | IF UNDER 24 HRS.        | 2c. DATE PRONOUNCED DEAD  | 2d. HOUR                                     |
| FEMALE  | WHITE  | APRIL 3, 1911   | 69 YRS.   |   |                         | May 26 1980   | 3A M   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?                             | 8. MARRIED  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |                         |   |  |
| NEW JERSEY  | U.S.A.   | XX NEVER MARRIED  | Montgomery  | MD  |                         |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |                         |   |  |
| Wheaton   | 2906 Silver Ridge Ave                                    | DRY CLEANING  | BUSINESS  |   |                         |   |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |                         |   |  |
| MARYLAND  | MONTGOMERY   | WHEATON   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2906 BLUERIDGE AVENUE   |                         |   |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME                                 |   |   |   |                         |   |  |
| Dominio Samogna   | Anna M. Gianantonio                                      |   |   |   |                         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  | 16b. SOCIAL SECURITY NO.                                 | 17. INFORMANT   | ADDRESS   |   |                         |   |  |
| NO  | 225-05-0915  | WILLIAM E. HALL   | SAME AS 13 HUSBAND  |   |                         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |   |   |                         |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:   |  |   |   |   |                         |   |  |
| IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>   |  |   |   |   |                         |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |                         |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |  |   |   |   |                         |   |  |
| (b) <u>Carcinoma of Uterus</u>  |  |   |   |   |                         |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |                         |   |  |
| (c)   |  |   |   |   |                         |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |   |   |                         |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |   |   |                         | 20. AUTOPSY?  |  |
|   |  |   |   |   |                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                         |   |  |
|   |  | HOUR A.M. MONTH DAY YEAR                                      |   |   |                         |   |  |
|   |  | P.M. 19   |   |   |                         |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION   |                         |   |  |
|   |  |   |   | STREET CITY OR TOWN COUNTY STATE  |                         |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |   |   |                         |   |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |   | DATE SIGNED   |                         |   |  |
| John G. Ball  |  | M.D. D-Posty  |   | May 26 1980   |                         |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |   |   |                         |   |  |
| JOHN G. BALL  |  | BETHESDA, MARYLAND  |   |   |                         |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |                         | 23d. LOCATION   |  |
| BURIAL  |  | 5/29/80   |   | GATE OF HEAVEN  |                         | SILVER SPRING MONT MD.  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR                                 |   | 25b. REGISTRAR'S SIGNATURE  |                         |   |  |
| FRANCIS J. COLLINS  |  | MAY 29 1980   |   | Ritzy Kelly   |                         |   |  |
| NAME  |  | ADDRESS   |   |   |                         |   |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |   |   |   |                         |   |  |

11/15/2002



FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 2 8 1

REG. NO.

|  |  |  |  |   |   |   |
|--|--|--|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>NATHAN HALPERN</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 28, 1980</b>                      |   | 2b. HOUR<br><b>5:15 PM</b>                                      |   |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>SEPT. 21, 1881</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>98</b> YRS.             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>AUSTRIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD. |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PAPER &amp; TWINE</b> |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>MONTGOMERY</b>   |   | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>                       |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>BERYL HALPERN</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>CLARA (UNASCERTAINABLE)</b> |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>060 07 5404</b>                               |   | 17. INFORMANT ADDRESS<br><b>MRS. LILLIAN LUBAN, same as #13</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>chronic bronchitis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b><br><b>10 years</b> |  |  |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Poly myalgia rheumatica</b>   |  |  |  |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 19 78</b> , to <b>May 28 19 80</b> , that (I) (we) last saw the deceased alive on <b>May 28 19 80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.              |  |  |  |   |   |   |
| 22b. SIGNATURE<br><b>Mark S. Rosen MD</b>  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>May 29, 1980</b>   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MR. MARK ROSEN, M.D.</b>   |  | 22e. ADDRESS<br><b>1131 UNIVERSITY BOULEVARD, WEST, SILVER SPRING, MARYLAND</b>  |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5/30/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT HEBRON CEMETERY</b>  |   |   |
| 23d. LOCATION CITY OR TOWN<br><b>QUEENS</b>  |  | 23e. COUNTY<br><b>QUEENS</b>   |  | 23f. STATE<br><b>NEW YORK</b>   |   |   |
| 24. FUNERAL DIRECTOR<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>  |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>JUN 2 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |
| 26. ADDRESS<br><b>232 CARROLL STREET, N.W., WASHINGTON, D. C.</b>  |  |  |  |   |   |   |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 1 3 2 8 2   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Hayden W Hammond   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5-8-80  |  | 2b. HOUR MIN<br>9:30 PM   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 30 1911  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR<br>Engineer  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Montgomery Sil. Spr.  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1919 E.W. Hgwy.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George W. Hammond   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lola J. Sparks  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no  |  |   |  |
| 16b. SOCIAL SECURITY NO<br>none  |  | 17. INFORMANT<br>Hazel P. Hammond- (same as 13e)  |  | 17 ADDRESS<br>*** (wife)  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>plethora</u><br>(c) <u>post Right middle/lower lobe pneumonia</u> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>5-8-80   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Cancer lung Right   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-8-80 to 5-8-80, that (I) (we) lost saw the deceased alive on 5-8-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>V.C. DeGuzman MD   |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>5-9-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>V.C. DeGuzman MD  |  |   |  | 22e. ADDRESS<br>1234 19th NW Wash DC  |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5-12-1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Rockville Montgomery Md.   |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Epumphrey, Inc.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 16 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>H. Kelly  |  |
| 24 ADDRESS<br>8434 Ga. Ave., S.S. Md.  |  |   |  |   |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |   |  | 8 0 1 3 2 8 3   |  |
|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | FIRST MIDDLE LAST  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR  |  |
| RUBY M. HARDESTY  |  |  |  |  |  |  |  | 5-25-1980   |  | 2:50A M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN.  |  |
| female  |  | white  |  | Mar. 2 1907  |  | 87 YRS   |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |  |
| Maryland  |  | USA  |  |  |  | Montgomery MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Silver Spring   |  | Holy Cross Hospital  |  |  |  |  |  | Retired   |  | Hecht Co.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |  |  |   |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |   |  |
| Maryland  |  | Montgomery   |  | Sil. Spring  |  |  |  | 821 Philadelphia Avenue,  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |   |  |
| Benjamin R. Hardesty  |  |  |  | Eliza M. Giddings  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |
| no  |  |  |  | none   |  | 15111 Glade Drive, S.S. Md., Apt. 1C   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Disease</u>   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wk</u>  |  |
| 4379 } DUE TO, OR AS A CONSEQUENCE OF <u>Hypertension</u>   |  |  |  |  |  |  |  |   |  | may year  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |  |   |  |
|   |  |  |  | P.M. 19  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/23</u> 19 <u>80</u> to <u>5/25</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>5/24</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |   |  |   |  |
| IRA N. TUSLIN   |  |  |  | 8830 Cameron St., Silver Spring, Md.   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| Burial  |  |  |  | 5-27-80  |  | Rock Creek Cemetery  |  | Washington, DC  |  |   |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| Warner E. Pumphrey  |  |  |  | MAY 29 1980  |  |  |  | [Signature]   |  |   |  |
| 434 Ga. Ave., S.S. Md.  |  |  |  |  |  |  |  |   |  |   |  |

Chas E. W. W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                          |  |  |  |  |  |   |  |
|--|--|--|--------------------------|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO. 8013284         |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH        |  |  | 2b. HOUR   |  |  |   |  |
| John C. Harding  |  |  | May 5, 1980              |  |  | 10:00 PM   |  |  |   |  |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR   |   |  |
| Male   |  | White  |                          | 11 20 1896   |  | 83   |  | MONTHS DAYS HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |   |  |
| New York   |  | USA  |                          |  |  | Montgomery County MD.  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                          |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |  |
| Bethesda   |  | Carriage Hill-Bethesda/In. 20014   |                          |  |  | Elec. Contractor   |  | Self-employed  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13b. COUNTY              |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |
| D.C.   |  |  |                          |  |  | Washington   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME |  |  | 16. ADDRESS  |  |  |   |  |
| Damon  |  |  | Harding                  |  |  | Estella Wood   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO. |  |  | 17. INFORMANT  |  |  | ADDRESS   |  |
| No   |  |  | 577-10-9378              |  |  | John C. Harding, Jr.   |  |  | 4875 Church Lane Galesville, MD                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |                          |  |  |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |                          |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u>   |  |  |                          |  |  |  |  |  |   |  |
| 4919   |  |  |                          |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |  |  |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |                          |  |  |  |  |  |   |  |
| b) <u>Chronic Bronchitis</u>   |  |  |                          |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |  |  |  |  |  |   |  |
| c) <u>Cerebral Atrophy</u>   |  |  |                          |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                          |  |  |  |  |  |   |  |
| Cerebral Atrophy   |  |  |                          |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |
|  |  |  |                          |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |                          | 21c. HOW INJURY OCCURRED   |  | 21d. INJURY OCCURRED   |  |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |                          | ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2  |  |  |  |  |   |  |
|  |  | P.M. 19  |                          |  |  |  |  |  |   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |                          | CITY OR TOWN   |  | COUNTY   |  | STATE  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |                          | STREET   |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 19 78</u> , to <u>present</u> 19 <u>80</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive or above, (I) <input checked="" type="checkbox"/> did not view the body after death. |  |  |                          |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |                          |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |   |  |
| <u>Harold I. Passes</u>  |  |  |                          |  |  |  |  | MAY 5 1980   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |                          |  |  |  |  |  |   |  |
| HAROLD I. PASSES M.D.  |  | 4425 Montgomery Ave Bethesda Md 20814  |                          |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | COUNTY STATE   |   |  |
| Cremation  |  | 5/6/80   |                          | Metropolitan Crem.   |  | Alexandria   |  | Virginia   |   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |                          | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |   |  |
| Robert A. Humphrey Funeral Homes, P.A. Bethesda, Maryland  |  | MAY 9 1980   |                          | <u>Robert A. Humphrey</u>  |  |  |  |  |   |  |

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                              |   |  |                                    |   |  |  |   | 8 0 1 3 2 8 5   |      |          |
|---|--|------------------------------|---|--|------------------------------------|---|--|--|---|-----------------|------|----------|
| 1. FOR STATE REGISTRAR  |  |                              | CERTIFICATE OF DEATH  |  |                                    |   |  |  |   | REG. NO.        |      |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                              | FIRST   | MIDDLE   | LAST                               | 2a. DATE OF DEATH   |  |  | MONTH   | DAY             | YEAR | 2b. HOUR |
| Robert Lee Harrell, Jr.   |  |                              |   |  |                                    | May 2, 1980   |  |  |   |                 |      | 8:23a    |
| 3 SEX   |  | 4 RACE                       |   | 5 DATE OF BIRTH  |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR                            |   | IF UNDER 24 HRS |      |          |
| Male  |  | White                        |   | May 6, 1943  |                                    | 36  |  | YRS  |   | MONTHS          |      |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |  | MD.   |                 |      |          |
| Virginia  |  | U.S.A.                       |   |  |                                    | Montgomery County   |  |  |   |                 |      |          |
| 10 CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                 |      |          |
| Bethesda  |  |                              | Clinical Center, NIH  |  |                                    | Prdd. Mgr.  |  |  | Fertilizer Co   |                 |      |          |
| 13a. STATE  |  |                              | 13b. COUNTY   |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS   |                 |      |          |
| Virginia  |  |                              | Ind.Co.   |  | Chesapeake                         |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 537 Cameo Terrace   |                 |      |          |
| 14 FATHER'S NAME  |  |                              | 15 MOTHER'S MAIDEN NAME   |  |                                    | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO   |                 |      |          |
| Robert Lee Harrell Sr.  |  |                              | Martha  |  |                                    | No.   |  |  | Not Known   |                 |      |          |
| 17 INFORMANT  |  |                              | ADDRESS   |  |                                    | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Asthma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Seizure Disorder</u> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immed.</u><br><u>4 years</u><br><u>2 weeks</u> |                 |      |          |
| Mrs. Donna Harrell (same)   |  |                              |   |  |                                    | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>Iatrogenic Cushing's Syndrome</u>  |  |  |   |                 |      |          |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                    | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                    |                 |      |          |
|   |  |                              |   |  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |                 |      |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |                 |      |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |                 |      |          |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 30, 1978</u> to <u>May 2, 1980</u> , that (we) last saw the deceased alive on <u>May 2, 1980</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |                              |   |  |                                    |   |  |  |   |                 |      |          |
| 22b. SIGNATURE<br><u>Louis F. Fries III</u>   |  |                              | DEGREE<br><u>MD</u>   |  |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  | 22c. DATE SIGNED<br><u>5/02/80</u>  |                 |      |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>LOUIS F. FRIES III M.D.</u>   |  |                              | 22e. ADDRESS<br><u>Clinical Center, National Institutes of Health, Bethesda, Md. 20205</u>                |  |                                    |   |  |  |   |                 |      |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |                 |      |          |
| Burial  |  |                              | May 5, 1980   |  | Chesapeake Mem. Gard               |   |  | Chesapeake Ind.Co. Va.                     |   |                 |      |          |
| 24 FUNERAL DIRECTOR<br>NAME<br><u>W.W. Chambers Co., Inc.</u>   |  |                              | ADDRESS<br><u>Sil. Sprg., Md.</u>   |  |                                    | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 8 1980</u>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey McBrady</u>  |                 |      |          |

Virginia

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

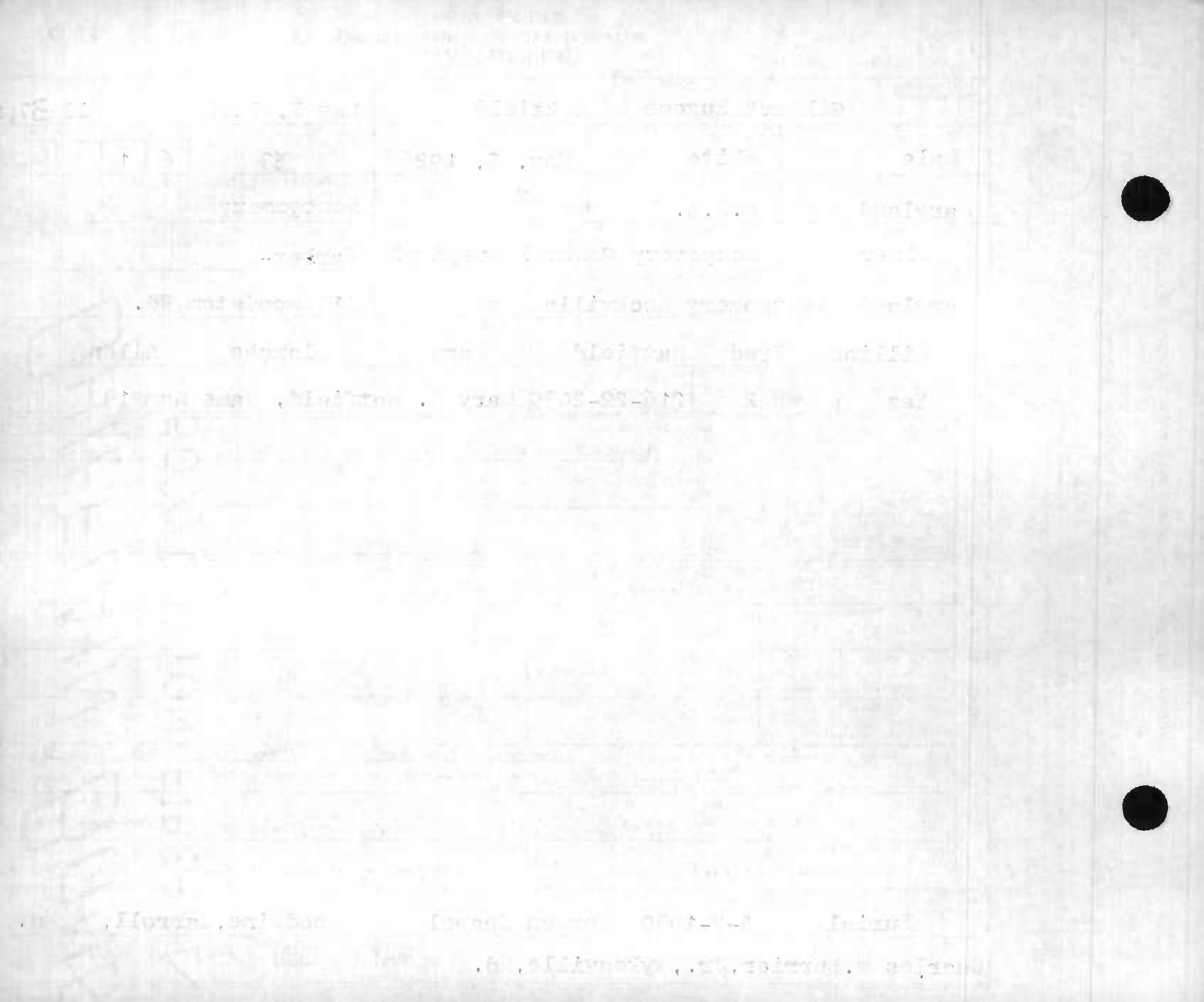
1- FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |  |   |  |   |   |  |
|---|--|---|--|--|--|--|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Gilbert Eugene Hatfield</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 3, 1980</b>  |  |  | 2b. HOUR<br><b>11:37p</b>  |   |  |   |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 2, 1926</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS  |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>6 1</b>   |   |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |   |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Barber-</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Montgomery</b>   |  |  | 13c. CITY OR TOWN<br><b>Rockville</b>  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Fred Hatfield</b>   |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Blanche Allen</b>                          |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>WW 2</b> |  |
| 17 INFORMANT<br>ADDRESS<br><b>Mary E. Hatfield, Same As #13</b>   |  |   |  |  |  |  |   |  |   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>586-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>                                    |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>DIABETES Mellitus, Renal Failure, Pneumonia</b>   |  |   |  |  |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>5/3/80</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Diabetic RENAL FAILURE FOR HEMODIALYSIS</b> |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                             |  |  | 21f. LOCATION<br>STREET  |   | CITY OR TOWN   |   | STATE                                   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>January 13, 1980</b> to <b>May 3, 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>May 3, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.                                    |  |   |  |  |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Barry Hecht</b>  |  |   | DEGREE<br><b>MD</b>  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>MAY 4, 1980</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Barry Hecht</b>   |  |   | 22e. ADDRESS<br><b>10620 GEORGIA AVENUE Silver Spring</b>  |  |  |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>5-7-1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Morgan Chapel</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodbine, Carroll, Md.</b> |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Charles W. Burrier, Jr., Sykesville, Md.</b>   |  |   |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 7 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Barry Hecht</b>   |   |   |  |

MEDICAL CERTIFICATION

29

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 1 3 2 8 1

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |  |   |
|---|--|--|---|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Esther E Hawse</b>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 14 80</b>   |   | 2b HOUR<br><b>4<sup>PM</sup></b>   |   |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>White</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 8, 1912</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>  |   |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>                                       |   |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4858 Battery Lane #101</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Saleslady</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>   |  | 13b COUNTY<br><b>Montgomery</b>  | 13c CITY OR TOWN<br><b>Bethesda</b>   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis Gilliam</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gladys Lily</b>  |   |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br><b>219-07-8231</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>James P. Hawse, Item 13</b>                                     |   |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Vascular Disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |   |  |   |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1945</b> to <b>date</b> , 19 <b>45</b> , that (we) lost saw the deceased alive on <b>April 24, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |
| 22b. SIGNATURE<br><b>John G. Ball</b>   |  | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>May 14, 1980</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John G. Ball, M.D.</b>  |  | 22e. ADDRESS<br><b>Bethesda, Maryland</b>  |   |  |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 17, 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Montg., Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 19 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>   |   |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Olin L. Molesworth, Damascus, Md.</b>   |  |  |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please fill in as soon as possible.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

W. Va. U.S.A. 11.11.11  
Maryland, Baltimore, 11.11.11  
Louisiana, 11.11.11  
No 51-07-5231, 11.11.11  
11.11.11

John A. Hall, 11.11.11  
11.11.11  
11.11.11  
11.11.11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8013288   |  |  |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR  |  |
| SUSAN RUTH HAY   |  |  |  |  |  |  |  | 5-24-80   |  | 4:30 A M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN                               |  |
| Female   |  | White  |  | 2 20 84  |  | 36 YRS.  |  |   |  |   |  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |  |
| 99   |  | U.S.A.   |  |  |  | Montgomery County MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |   |  |   |  |
| 90 TAKOMA PARK   |  | SLIGO GARDENS Nursing Home   |  |  |  |  |  |   |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |   |  |   |  |
| 35   |  | Medical Sec.   |  |  |  |  |  |   |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |   |  |
| MD   |  | MONTG  |  | TAKOMA PARK  |  | YES  |  | 6 Jefferson Ave.  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |   |  |   |  |
| 52 Carl Von Hake   |  | Inez Johnson   |  |  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  | ADDRESS  |  |   |  |   |  |
| 1 No   |  | 523-64-8841  |  | Conrad Hay   |  | 6 Jefferson Ave. - Takoma Park   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2500 Diabets melitus   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several w. |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/25/80 to 5/24/80, that (I) (we) lost saw the deceased alive on 5/23/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED   |  |   |  |   |  |
| David Cromwell   |  | MD   |  |  |  | 5/24/80  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |   |  |
| David Cromwell   |  | 831 University Blvd E. Silver Spring, Md 20903   |  |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| Removal  |  | May 24, 80   |  | George Wash. Med. Sch  |  | Washington, D.C.   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25. DATE RECEIVED BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |
| METROPOLITAN FUNERAL SER   |  | 5517 VINE ST ALEXANDRIA, VA.   |  | JUN 1 1980   |  |  |  |   |  |   |  |

Ch 1

Von

Hals

1000

1000

No

Conrad May

6 Jefferson Ave. - Toledo, Ohio

May 24, 80. Capt. A. W. Hall, 2nd. Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |   |  |  |                             | 8 0 1 3 2 8 9   |  |   |  |
|---|--|---|--|--|---|---|--|--|-----------------------------|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |  |   |   |  |  |                             | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frank W. Heinrich</b>   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 9 80</b>                  |   |  |  | 2b. HOUR<br><b>2:31</b> P M |   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 10 07</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |                             | 8. IF UNDER 24 HRS<br>HOURS MIN   |  |   |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                               |  |  |                             |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Fairland Nursing Home</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. - Carpenter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |                             |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |   |   |  |  |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3117 Varnum St.</b> |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Pr. Geo.</b>  |  | 13c. CITY OR TOWN<br><b>Mt. Rainier</b>  |   |   |  |  |                             |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Carl Heinrich</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaretha Ries</b> |   |  |  |                             |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>   |  | 17. INFORMANT<br><b>Alice E. Heinrich (above address)</b><br>(Wife)  |   |   |  |  |                             |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b>   |  |   |  |  |   |   |  |  |                             | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Days</b>                                  |  |   |  |
| 3320<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Parkinson Disease</b>  |  |   |  |  |   |   |  |  |                             | Years   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |   |   |  |  |                             |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |   |   |  |  |                             |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                             |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |                             |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |                             |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 78</b> to <b>5/9</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>5/6</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |   |  |  |                             |   |  |   |  |
| 22b. SIGNATURE<br><b>Byrl D. Johnson</b>  |  |   |  |  |   | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                             | 22c. DATE SIGNED<br><b>5-9-1980</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Byrl D. Johnson</b>   |  |   |  |  |   | 22e. ADDRESS<br><b>4404 Queensbury Rd. Riverdale Md</b>                                     |  |  |                             |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/13/1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Geo. Md.</b>                 |  |  |                             |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Nalley's F.H. Inc.</b>   |  | ADDRESS<br><b>Mt. Rainier, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 10 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey McCreedy</b>                                       |  |  |                             |   |  |   |  |

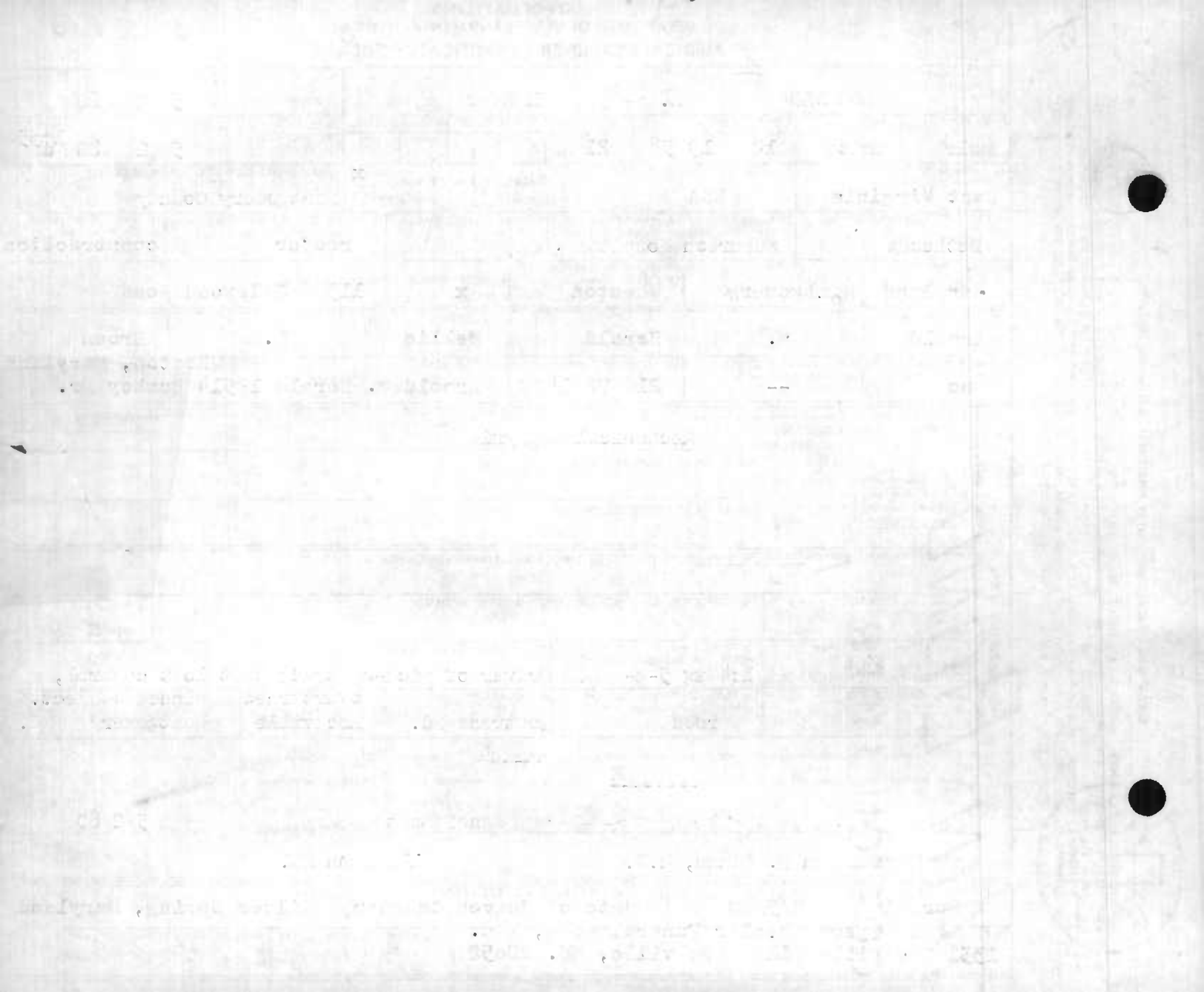
BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                  |  |  |  |  |  |   |  | REG. NO. 13290  |  |  |  |                        |  |
|--|--|----------------------------------|--|--|--|--|--|---|--|---|--|--|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DONALD R. HERALD</b>  |  |                                  |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5 2 1980</b> |  | 2b. HOUR <b>M</b>  |  |                        |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b>             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 19 58</b>   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) <b>21</b> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>5 2 1980</b>           |  | 2d. HOUR <b>1:55</b> M |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  |                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD. |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  |                                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital (DOA)</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>roofer</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>construction</b>             |  |                        |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                  |  |  |  |  |  |   |  |   |  |  |  |                        |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b> |  | 13c. CITY OR TOWN<br><b>Wheaton</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  | 13e. STREET ADDRESS<br><b>11506 Idlewood Road</b>   |  |   |  |  |  |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arnold P. Herald</b>  |  |                                  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie L. Brown</b>  |  |   |  |   |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES) <b>--</b>  |  |                                  |  | 16b. SOCIAL SECURITY NO.<br><b>216 72 1490</b>   |  | 17. INFORMANT<br><b>Arnold P. Herald</b>   |  |   |  | ADDRESS <b>Wheaton, Maryland 12514 Bushey Dr.</b>   |  |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Mechanical asphyxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                                  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                  |  |  |  |  |  |   |  |   |  |  |  |                        |  |
| 19a. DATE OF OPERATION   |  |                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |  |  |                        |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1:40xx 5-2- 1980</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>Driver of pick-up truck that lost control,</b> |  |   |  |   |  |  |  |                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Montrose Rd. Rockville Montgomery Md.</b>                                  |  |   |  |   |  |  |  |                        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                                  |  |  |  |  |  |   |  |   |  |  |  |                        |  |
| ACTUAL SIGNATURE <b>Ann M. Dixon</b>   |  |                                  |  |  |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>5/2/80</b>   |  |  |  |                        |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                                  |  |  |  | ADDRESS <b>111 Penn St.</b>  |  |   |  |   |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                                  |  | 23b. DATE<br><b>5/5/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Maryland</b>                            |  |  |  |                        |  |
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home, Inc.</b><br><b>1331 Rockville Pike Rockville, Md. 20852</b>   |  |                                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 7 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCurdy</b>   |  |   |  |  |  |                        |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

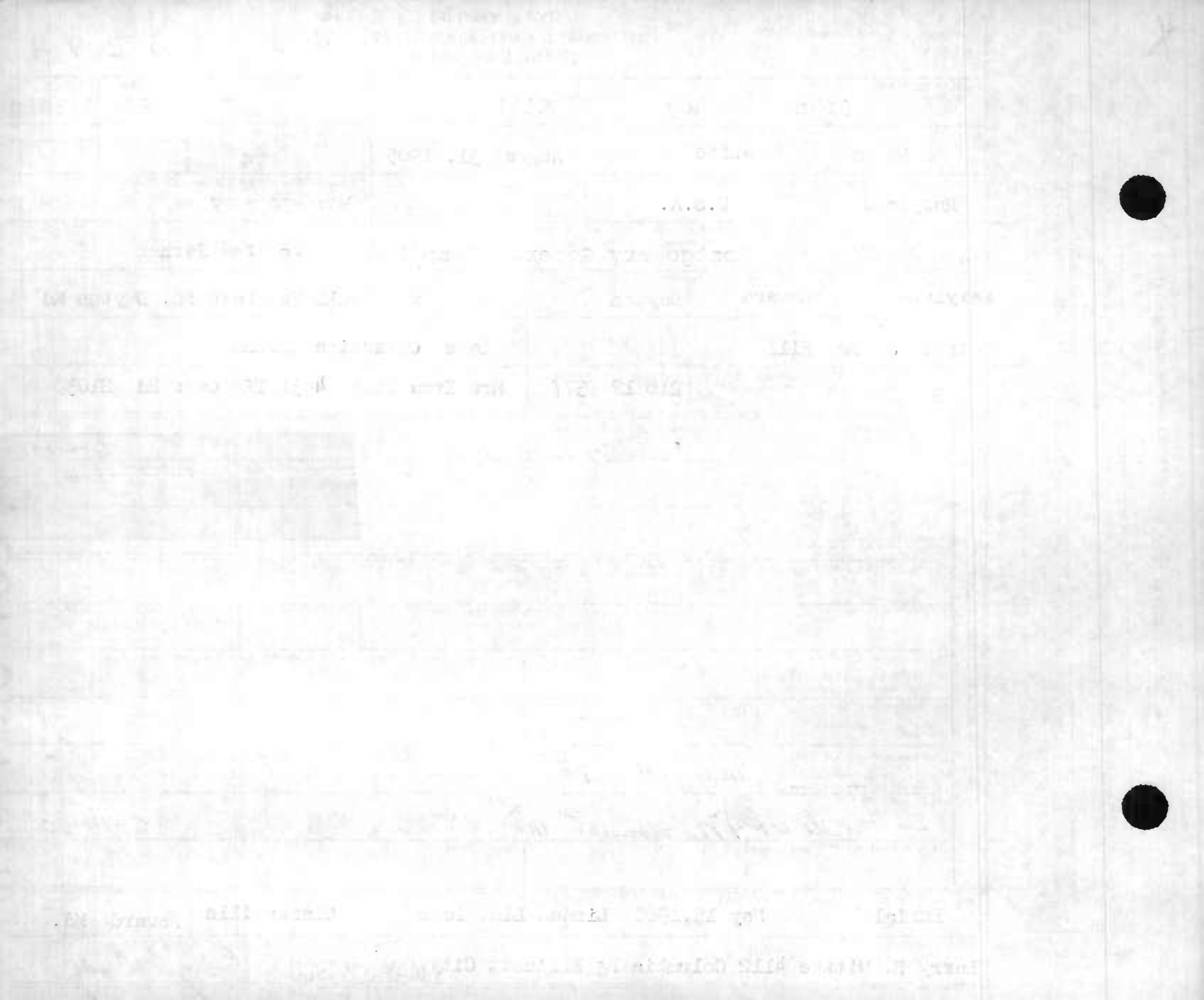
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 2 9 1

REG. NO.

|  |  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH                                |  |  | 2b. HOUR   |   |  |  |
| DECEASED NAME (TYPE OR PRINT)  |  |  | MONTH DAY YEAR                                   |  |  | HOURS MIN.   |   |  |  |
| John Roy Hill  |  |  | 05 14 80   |  |  | 11:01p   |   |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR   |  |
| Male   |  | White  |  | August 31, 1905  |  | 74 YRS   |   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |
| Maryland   |  | U.S.A.   |  |  |  | Montgomery MD  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Olney  |  | Montgomery General Hospital  |  |  |  | Retired Farmer   |   |  |  |
| 13a. STATE   |  |  | 13b. CITY OR TOWN                                |  | 13c. STREET ADDRESS  |  | 13d. INSIDE CITY LIMITS?  |  |  |
| Maryland   |  |  | Howard Dayton                                    |  | 4631 Ten Oaks Rd. Dayton Md  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME                         |  |  |  |   |  |  |
| late John Hill   |  |  | late Christina Kruhm                             |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.                         |  | 17. INFORMANT  |  | ADDRESS   |  |  |
| No   |  |  | 218 12 7377                                      |  | Mrs Irma Hill  |  | 4631 Ten Oaks Rd 21036  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Carcinoma of lung.</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF      |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
|  |  |  |  |  |  |  |   | 6 mos.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a):  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR                         |  |  |  |   |  |  |
|  |  |  | P.M. 19  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY                             |  | 21f. LOCATION  |  |   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 7</u> , 19 <u>80</u> , to <u>May 14</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>May 14</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE   |  |  |  |  |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| <u>Frederick Norman, M.D.</u>  |  |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 5-14-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  | 22e. ADDRESS   |   |  |  |
|  |  |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |
| Burial   |  |  | May 15, 1980                                     |  | Linden Linthicum   |  | Clarksville Howard, Md.   |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                     |  |
| NAME Harry H. Witzke 4112 Columbia Rd Ellicott City  |  |  |  |  |  | MAY 22 1980  |   | <u>Frederick Norman</u>  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 1 3 2 9 2   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Walter G Hiner</u>   |  |  |  | 2a. DATE OF DEATH MONTH <u>5</u> DAY <u>10</u> YEAR <u>80</u>   |  |   |  |
| 3 SEX <u>Male</u>  |  |  |  | 2b. HOUR <u>1:20 P.M.</u>   |  |   |  |
| 4 RACE <u>White</u>  |  | 5 DATE OF BIRTH MONTH <u>March</u> DAY <u>4</u> YEAR <u>1901</u>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Minn.</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Mont.</u>  |  |
| 10 CITY OR TOWN OF DEATH <u>Bethesda</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Bethesda Retirement Center</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>US Army</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Civilian</u>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 13a. STATE <u>Md.</u>  |  | 13b. COUNTY <u>Mont.</u>   |  | 13c. CITY OR TOWN <u>S.S.</u>   |  | 13e. STREET ADDRESS <u>405 Burnt Mills Ave.</u>   |  |
| 14 FATHER'S NAME FIRST <u>Gustav</u> MIDDLE <u>N.</u> LAST <u>Hiner</u>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Minnie</u> MIDDLE <u>Hedberg</u> LAST <u></u>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>  |  | 16b. SOCIAL SECURITY NO. <u>579 32 0086</u>  |  | 17 INFORMANT ADDRESS <u>Esther Hiner (Wife) same as above</u>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest.</u>   |  |  |  |   |  |   |  |
| 4370 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic brain syndrome</u>  |  |  |  |   |  |   | <u>2 1/2 mos.</u>                            |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Deterioration of brain disease.</u>  |  |  |  |   |  |   | <u>7 1/2 mos.</u>                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR <u></u> A.M. MONTH <u></u> DAY <u>19</u> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>10/77</u> 19 <u></u> , to <u>5/10</u> 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>3/10/80</u> 19 <u></u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <u>Bernard J. Walsh</u> DEGREE <u></u>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED <u>5/10/80.</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Bernard J. Walsh</u>  |  |  |  | 22e. ADDRESS <u>1800 Eye St. N.W. - D.C.</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE <u>5/14/80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>   |  | 23d. LOCATION CITY OR TOWN <u>Rockville</u> COUNTY <u>Mont.</u> STATE <u>Md.</u>  |  |
| 24 FUNERAL DIRECTOR NAME <u>Hines/Rinaldi F.H.11800</u> ADDRESS <u>N.H.Ave.S.S.Md.</u>   |  |  |  | 25a. DATE REC'D BY REGISTRAR <u>MAY 14 1980</u>   |  |   |  |

RECEIVED 12/3/01

RECEIVED 12/3/01



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.

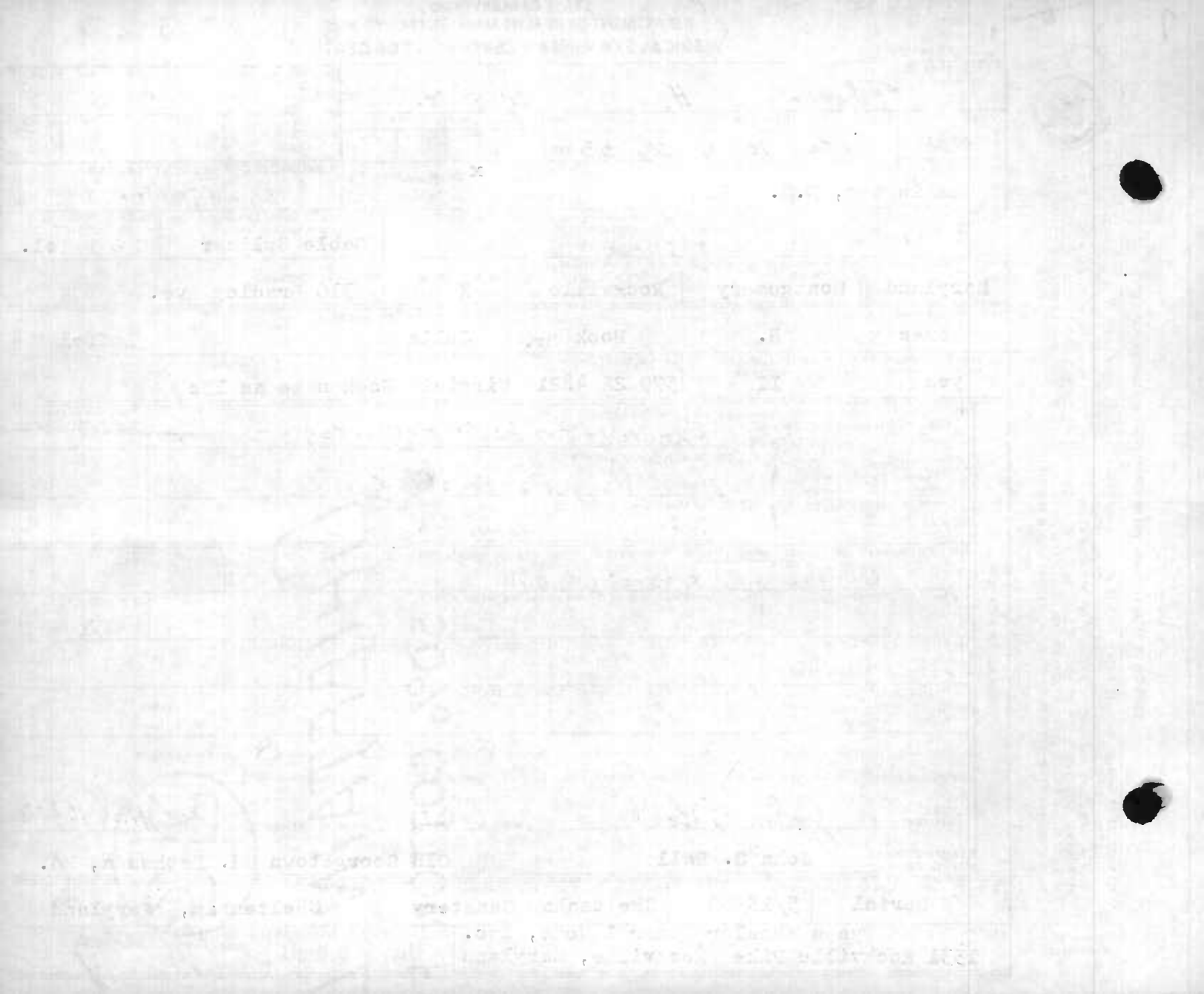
BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

| FOR<br>1- STATE<br>REGISTRAR   |  |                                  |  |   |  |   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                      |  |  |  |                              |  |  |  |  |  | REG. NO.                     |  |
|--|--|----------------------------------|--|---|--|---|--|---|--|---|--|--|--|------------------------------|--|--|--|--|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Thomas H. Hook Jr.</b>  |  |                                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>5-9 1980</b> |  |  |  |                              |  |  |  |  |  | 2b. HOUR<br><b>11:00 P M</b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>          |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10 6 26</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>53 YRS.</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD<br><b>May 10, 1980</b>              |  | 2d. HOUR<br><b>11:00 P M</b> |  |  |  |  |  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>   |  |                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD</b> |  |                              |  |  |  |  |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  |                                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cable Splicer</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>C &amp; P Tel.</b>   |  |                              |  |  |  |  |  |                              |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                  |  |   |  |   |  |   |  |   |  |  |  |                              |  |  |  |  |  |                              |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b> |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>310 Bradley Ave.</b>  |  |   |  |  |  |                              |  |  |  |  |  |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas H. Hook Sr.</b>  |  |                                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Laffel</b> |   |  |   |  |   |  |  |  |                              |  |  |  |  |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>yes</b>   |  |                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 17. INFORMANT<br><b>Virginia Hook same as 13e</b>   |  |   |  | ADDRESS   |  |  |  |                              |  |  |  |  |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pancreatitis Acute Hemorrhagic -</b><br><b>5772</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>Hemorrhage Pancreatic Cyst.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Gastritis c Hemorrhage -</b>                   |  |                                  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |                              |  |  |  |  |  |                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Cerebral infarction old.</b>   |  |                                  |  |   |  |   |  |   |  |   |  |  |  |                              |  |  |  |  |  |                              |  |
| 19a. DATE OF OPERATION   |  |                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |  |  |                              |  |  |  |  |  |                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |   |  |  |  |                              |  |  |  |  |  |                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |                              |  |  |  |  |  |                              |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                  |  |   |  |   |  |   |  |   |  |  |  |                              |  |  |  |  |  |                              |  |
| ACTUAL SIGNATURE<br><b>John G. Ball</b>  |  |                                  |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  |   |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br><b>May 10, 1980</b>                           |  |                              |  |  |  |  |  |                              |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>John G. Ball</b>  |  |                                  |  | ADDRESS<br><b>Old Georgetown Rd. Bethesda, Md.</b>  |  |   |  |   |  |   |  |  |  |                              |  |  |  |  |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/13/80</b>      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cheltenham Cemetery</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cheltenham, Maryland</b>   |  |   |  |  |  |                              |  |  |  |  |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Tyson Wheeler Funeral Home, Inc.</b>  |  |                                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 15 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |  |                              |  |  |  |  |  |                              |  |
| ADDRESS<br><b>1331 Rockville Pike Rockville, Maryland</b>  |  |                                  |  |   |  |   |  |   |  |   |  |  |  |                              |  |  |  |  |  |                              |  |

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1101



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8013294

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>THEODORE (NMN) HOOVER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 2, 1980                                |  | 2b. HOUR<br>2:25p.m.  |
| 3 SEX<br>MALE   | 4 RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>AUGUST 12, 1933   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>46 YRS.   | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Cuba   | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                            |  |   |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CLINICAL CENTER, BETHESDA, MD |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Office Worker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Drug Mfg.  |
| 13a. STATE<br>NEW JERSEY  |  |   | 13b. COUNTY<br>ESSEX  | 13c. CITY OR TOWN<br>MILLBURN  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Erladio Fernandez   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Esperanza Gonzans                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>264-58-8092  |   | 17. INFORMANT<br>ADDRESS (SAME AS ABOVE)<br>MRS. ENGRID HOOVER, WIFE                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Failure<br>3949<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF Mitral Valve Dehiscence<br>(c) DUE TO, OR AS A CONSEQUENCE OF rheumatic heart<br>Prosthetic valve replacement/ disease |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |   |
| 19a. DATE OF OPERATION<br>May 2, 1980   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Prosthetic mitral valve dehiscence  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |  |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (X) (this hospital) attended the deceased from April 27, 1980, to May 2, 1980, that (X) (we) last saw the deceased alive on May 2, 1980, and that in (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.   |  |   |   |  |   |
| 22b. SIGNATURE<br>Karl J. Karlson MD  |  | DEGREE  |   | 22c. DATE SIGNED<br>5/3/80   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KARL J. KARLSON  |  | 22e. ADDRESS<br>NATIONAL INSTITUTES OF HEALTH,<br>CLINICAL CENTER, BETHESDA, MD. 20205  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5/7/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Rosa Lima                                  |   |
| 23d. LOCATION<br>CITY OR TOWN<br>Short Hills, Essex, N. J.  |  | COUNTY  |   | STATE  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. W. Chambers Co., Silver Spring, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1980   |   | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McCreedy                                       |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

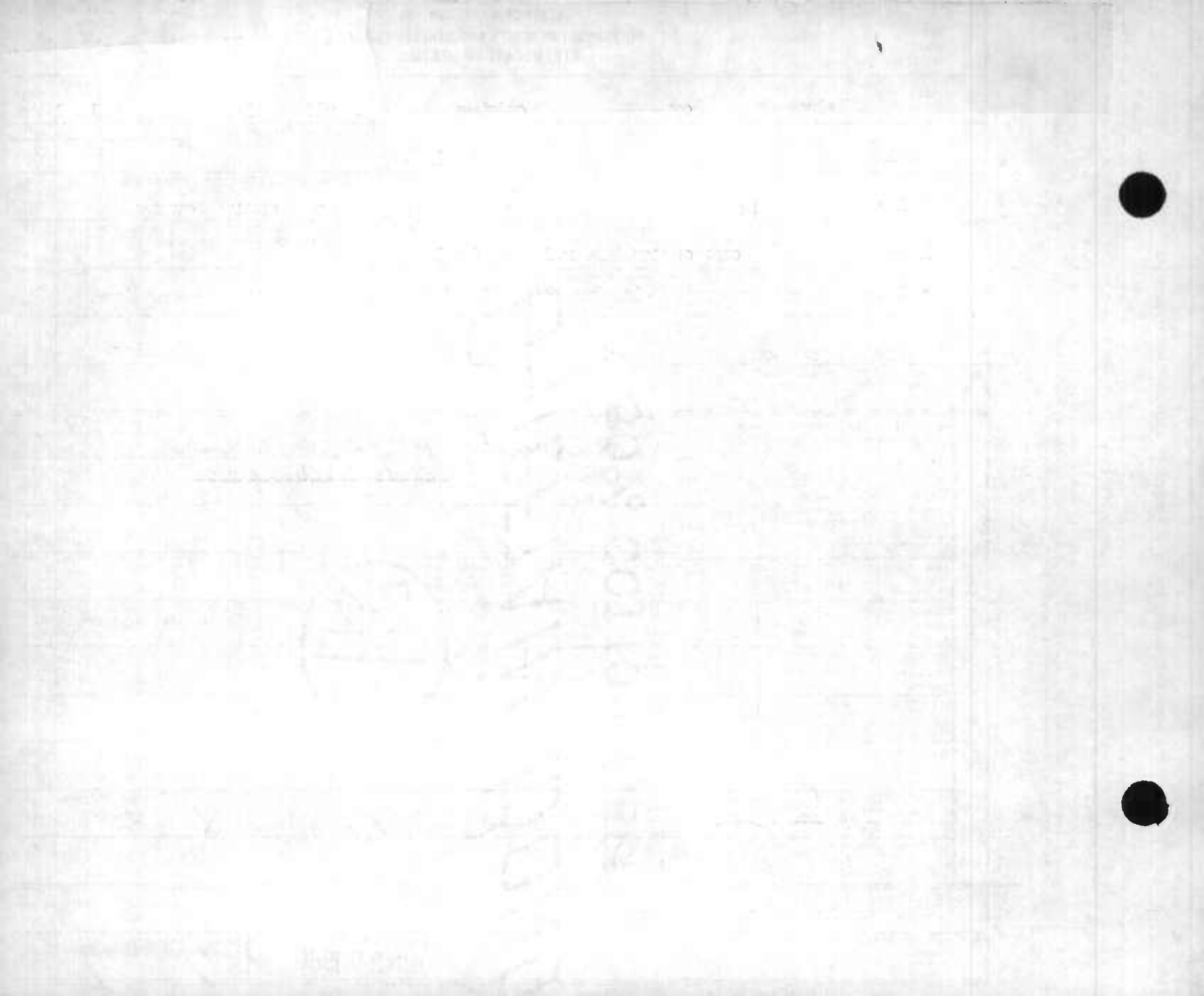
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |   |  |                            |  |  |
|--|--|--|--|--|--|---|---|--|----------------------------|--|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |   |  |                            |  |  |
| REG. NO.   |  |  |  |  |  |   |   |  |                            |  |  |
| 1. FOR STATE REGISTRAR   |  |  | 2a. DECEASED NAME (TYPE OR PRINT)  |  |  | 2b. DATE OF DEATH   |   |  | 2c. HOUR                   |  |  |
|  |  |  | Baby Boy Hopkins   |  |  | April 2, 1980   |   |  | 10:15AM                    |  |  |
| 3 SEX  |  |  | 4 RACE   |  | 5. DATE OF BIRTH   |   | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7b. HOUR                   |  |  |
| male   |  |  | White  |  | MONTH 4 DAY 02 YEAR 1980   |   | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  | MD.                        |  |  |
| Maryland   |  |  | U.S.A.   |  |  |   | Montgomery County   |  |                            |  |  |
| 10 CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                            |  |  |
| Olney  |  |  | Montgomery General Hospital  |  |  | N/A   |   |  |                            |  |  |
| 13a. STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS        |  |  |
| Maryland   |  |  | Montgomery   |  | Gaithersburg   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 324 East Diamond Ave.      |  |  |
| 14 FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |   |  |                            |  |  |
| Ira Douglas Tenly  |  |  | Theresa Lynn Hopkins   |  |  |   |   |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   |   | ADDRESS  |                            |  |  |
| No   |  |  |  |  |  |   |   |  |                            |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |   |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |   |  |                            |  |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia + Gross Anoxia</u>  |  |  |  |  |  |   |   |  |                            |  |  |
| 7651 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |   |  |                            |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |   |   |  |                            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |   |  |                            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |   |  |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |   |  |                            |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                            |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |                            |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |   |   |  |                            |  |  |
|  |  |  | P.M. 19  |  |  |   |   |  |                            |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY   |  |  | 21f. LOCATION   |   |  |                            |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | STREET CITY OR TOWN COUNTY STATE  |   |  |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death. |  |  |  |  |  |   |   |  |                            |  |  |
| 22b. SIGNATURE   |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED           |  |  |
|  |  |  | M.D.   |  |  |   |   |  |                            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS   |  |  |   |   |  |                            |  |  |
| ZAKARIA Oweis  |  |  |  |  |  |   |   |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION   |  | STATE                      |  |  |
| Body released to hospital  |  |  | 4-2-80   |  | 4-2-80   |   | CITY OR TOWN COUNTY   |  |                            |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |   |  |                            |  |  |
| NAME ADDRESS   |  |  | JUN 20 1980  |  |  |   |   |  |                            |  |  |

MEDICAL CERTIFICATION

0702 BP



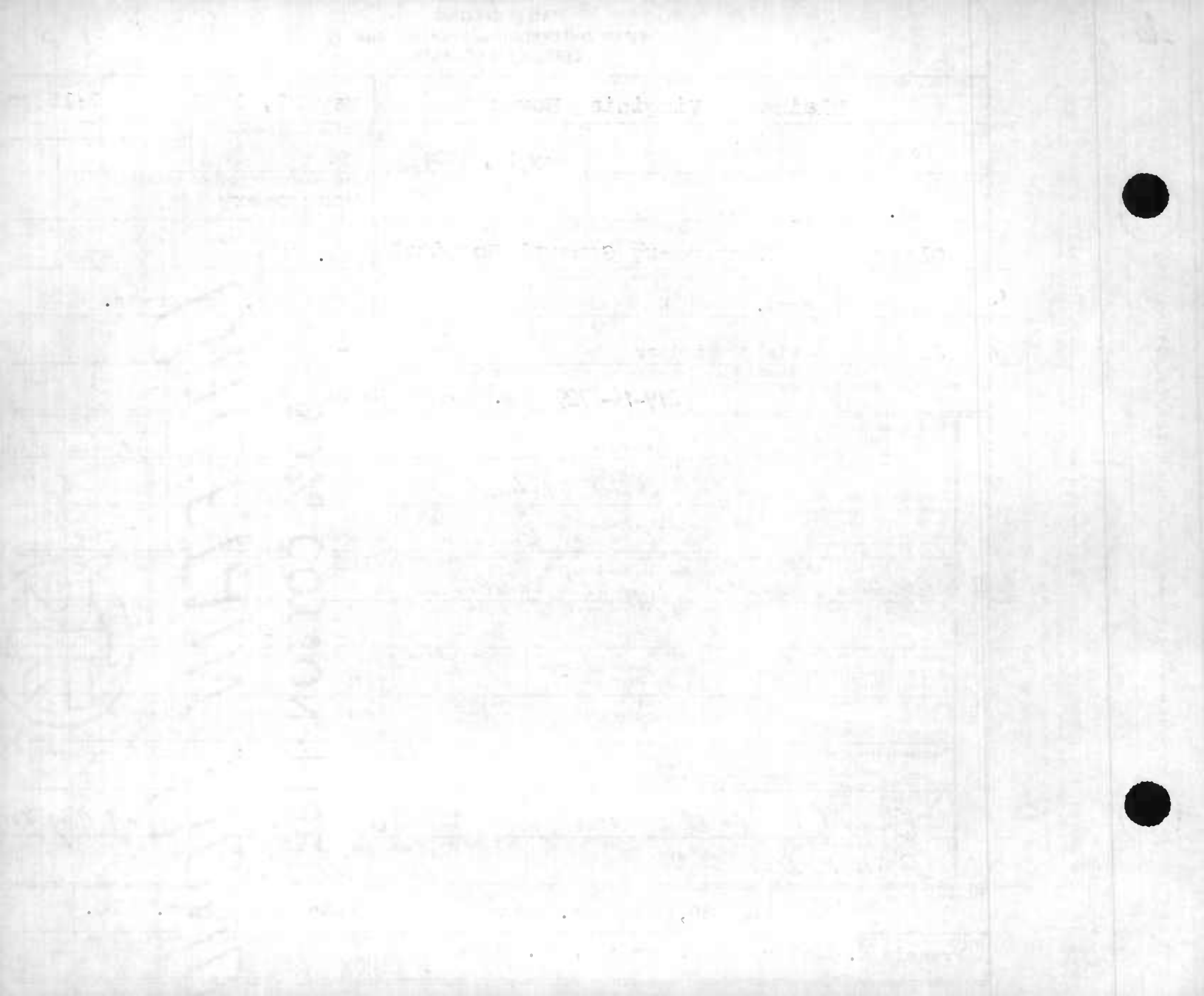
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |   |  |   |                            | 8 0 1 3 2 9 6  |  |
|--|--|--|--|---|--|---|--|---|----------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |   |                            | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Elaine Virginia Howes</b>   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 27, 1980</b>                           |  |   | 2b. HOUR<br><b>7:15 PM</b> |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 11, 1924</b>  |  | 6. AGE [IN YEARS (LAST BIRTHDAY)]<br><b>56</b> YRS.                               |  | IF UNDER 1 YEAR MONTHS DAYS   |                            | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                     |  |   |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>H. Wife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |                            |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  |   |  | 13b. COUNTY<br><b>Mont.</b>   |  | 13c. CITY OR TOWN<br><b>Damascus</b>  |                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Davis Windsor</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Laura - Burdette</b>             |  |   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-14-7729</b>   |  | 17. INFORMANT<br><b>G. Kenneth Howes</b>  |  | ADDRESS<br><b>Same as # 13</b>  |  |   |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shock</b><br>1830<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bowel obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ovarian Cancer metastatic, abdomen + pelvis</b> |  |  |  |   |  |   |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b><br><b>sev. whs.</b><br><b>3 yrs.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i)<br><b>Azotemia, ascites, hyperthyroidism.</b>  |  |  |  |   |  |   |  |   |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |                            |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1977</b> to <b>27 May 1980</b> , that (I) <del>was</del> last saw the deceased alive on <b>27 May 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |                            |  |  |
| 22b. SIGNATURE<br><b>Donald E. Dillon MD</b>   |  |  |  |   |  | DEGREE  |  | 22c. DATE SIGNED<br><b>27 May 80</b>  |                            | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald E. Dillon, M.D.</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>1811 Pr. Philip Br Olney, Md. 20832</b>                        |  |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>May 30, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Tabor</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Ethenison Mont. Md.</b>             |  |   |                            |  |  |
| 24. FUNERAL DIRECTOR<br><b>Francis H. Barber Laytonsville, Md. 20760</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 2 1980</b>                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McBrady</b>  |                            |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

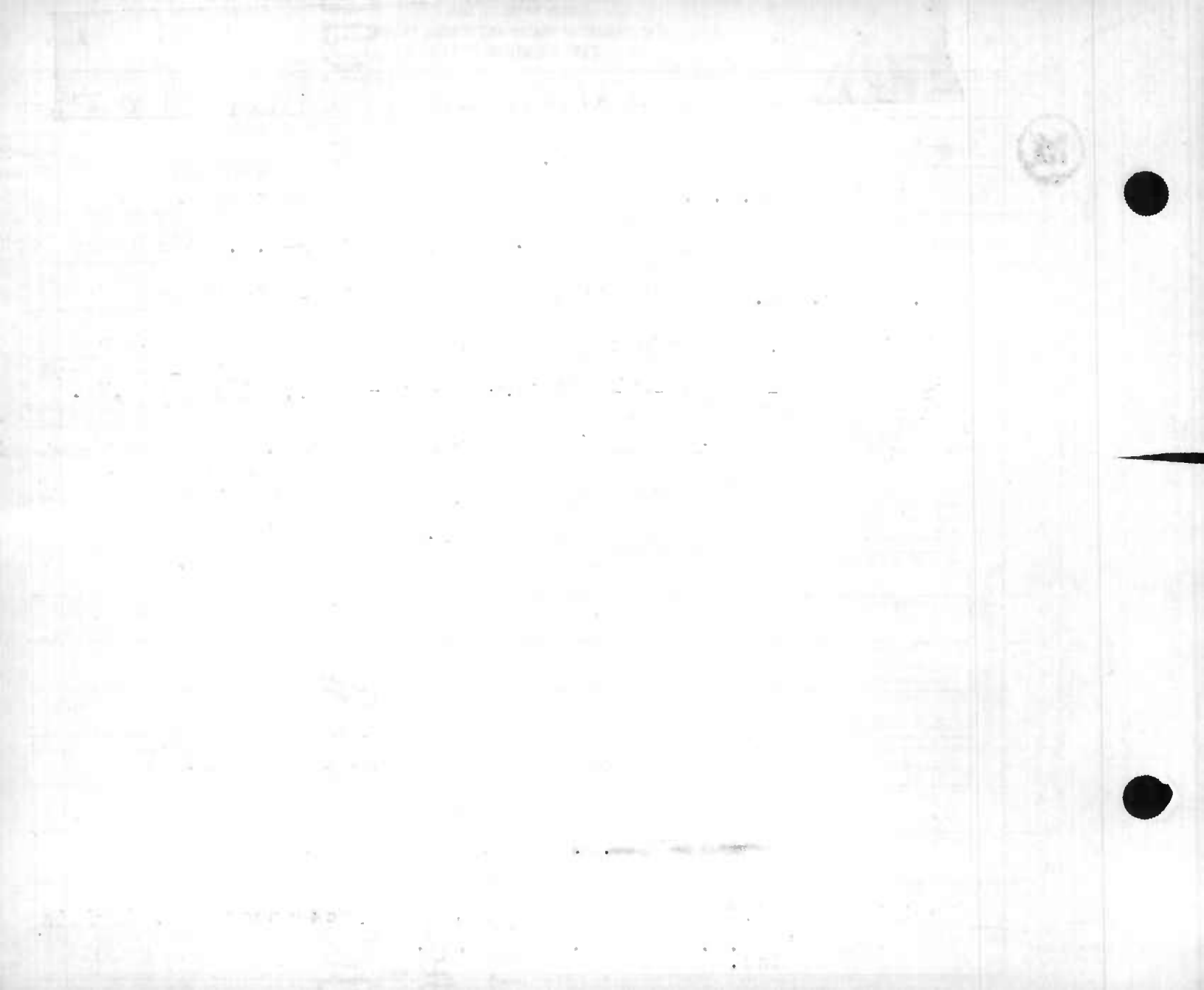
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 2 9 7

REG. NO.

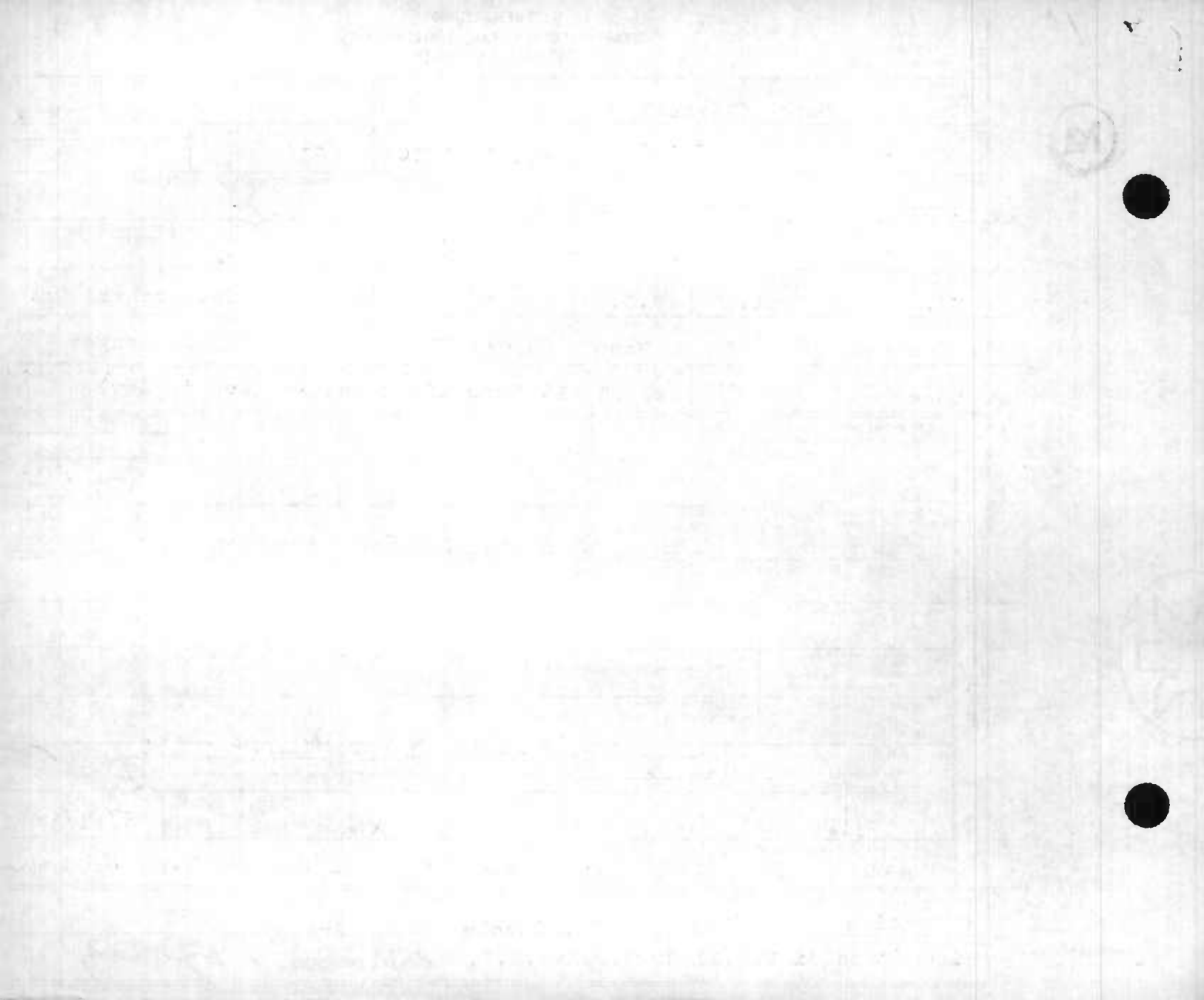
|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edna   |  | FIRST MIDDLE LAST<br>Huffman   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 5 1980  |  | 2b. HOUR<br>2:45 P.M.  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Caucasian  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 15 1917  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>Rockville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Potomac Valley Nursing Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Editor-U.S. Agriculture Dept   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  | 13b. COUNTY<br>Pr. Geo.  |  | 13c. CITY OR TOWN<br>Hyattsville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>William P. Huffman   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Verta Stutler  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>578-24-8172   |  | 17 INFORMANT<br>ADDRESS 1724-Crestwood Dr., Alexandria, Va.<br>Mary Lanier-  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized carcinoma</u><br>1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of the Breast</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Bone Dies + Bone metastasis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 years |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/30, 1976, to 5/5, 1980, that (I) (we) lost<br>saw the deceased alive on 5/1, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Rory Shannon</u>   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br>5/5/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rory Shannon   |  | 22e. ADDRESS   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5/9/1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Heavener Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Buckhannon W. Virginia   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Valley's F.H. Inc.   |  | ADDRESS<br>Mt. Rainier, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 12 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Rory Shannon   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For the certificate to be valid, it must be signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |                          |  |   |  |  | REG. NO.   |  |
|---|--|---|--|---|--------------------------|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |                          |  |   |  |  | 3 0 1 3 2 9 8  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH        |  |   |  |  | 2b. HOUR   |  |
| Berta (Bertel) Huhn   |  |   |  |   | May 13, 1980             |  |   |  |  | 2:38AM   |  |
| 3 SEX   |  | 4 RACE  |  | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |
| Female  |  | White   |  | Sept. 18, 1908  |                          | 71   |   | MONTHS   |  | DAYS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |  |  |  |  |
| Germany   |  | German National   |  |   |                          | Montgomery MD.   |   |  |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                          |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |
| Olney   |  | Montgomery General Hospital   |  |   |                          |  |   |  |  | Housewife  |  |
| 13a STATE   |  |   |  | 13b COUNTY  |                          | 13c CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?   |  | 13e STREET ADDRESS   |  |
| Md.   |  |   |  | Mont.   |                          | S.S.   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 15300 Pine Orchard Dr.   |  |
| 14 FATHER'S NAME  |  |   |  |   | 15. MOTHER'S MAIDEN NAME |  |   |  |  |  |  |
| Emanuel Mann  |  |   |  |   | Minna Behringer          |  |   |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  |   | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT  |  |  |  |  |
| None  |  |   |  |   | 220 92 6166              |  | 15301 Pine Orchard Dr. S.S. Md.<br>Hans Lichtenstein (Son in law) |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY:  |  |   |  |   |                          |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u>  |  |   |  |   |                          |  |   |  |  | 4 days   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u>  |  |   |  |   |                          |  |   |  |  | 3 weeks  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebellar pontine infarction</u>   |  |   |  |   |                          |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |                          |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          |  |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
|   |  |   |  |   |                          |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 24, 1980, to May 12, 1980, that (I) (we) lost<br>saw the deceased alive on May 12, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                          |  |   |  |  |  |  |
| 22b. SIGNATURE  |  |   |  | DEGREE  |                          |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| Hans Lichtenstein   |  |   |  |   |                          |  |   |  |  | 5/13/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |                          |  |   |  |  |  |  |
| HANS L. I. PASSES, M.D.   |  |   |  | 4425 Montgomery Ave Beltsdel Md 20014   |                          |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   |  | 23b. DATE   |                          | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| Cremation   |  |   |  | 5/14/80   |                          | Ft. Lincoln  |   | Brentwood PG MD  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |   |  |   |                          | 25a. DATE REC'D. BY REGISTRAR  |   |  |  |  |  |
| Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md  |  |   |  |   |                          | MAY 15 1980  |   |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 1 3 2 9 9  |  |
|---|--|---|--|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 20. DATE OF DEATH  |  |
| James A. Hunt   |  |   |  | May 20/1980 7:30 P.M.  |  |
| 3 SEX   |  | 4 RACE  |  | 5. DATE OF BIRTH   |  |
| male  |  | white   |  | May 8, 1912  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  |
| Wash. D.C.  |  | USA   |  | 68   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Silver Spring   |  | 114 St. Lawrence Dr.  |  | Montgomery MD.   |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Ret. Montgomery County Gov  |  |   |  |  |  |
| 13a STATE   |  |   |  | 13b. CITY OR TOWN  |  |
| Maryland  |  |   |  | Silver Spring  |  |
| 14 FATHER'S NAME  |  |   |  | 15 MOTHER'S MAIDEN NAME  |  |
| Ernest Hunt   |  |   |  | Goldie Dennison  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 17 INFORMANT   |  |
| no  |  |   |  | Alice E. Hunt (wife) #13   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  | 2-3 mo   |  |
| IMMEDIATE CAUSE (a) <u>uremia</u>   |  |   |  |  |  |
| 5829 DUE TO, OR AS A CONSEQUENCE OF   |  |   |  | 2  |  |
| (b) <u>chronic nephritis</u>  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |
| (c)   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |
| <u>Diabetes mellitus</u>  |  |   |  |  |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>49</u> to <u>20 May</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>19 May</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  | 22b. SIGNATURE<br><u>William D. Aud M.D.</u>  |  | 22c. DATE SIGNED<br><u>5/24/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |  |  |
| William D. Aud, M.D.  |  | 9006 Cilesville Bd. Sil. Sp. Md.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| BURIAL  |  | 5/23/80   |  | Gate of Heaven   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  | 23e. DATE REC'D. BY REGISTRAR   |  |  |  |
| Silver Spring, Md.  |  | MAY 27 1980   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME   |  | 24b. ADDRESS  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| W.W. Taltavull  |  | 4748 Wisc. Ave. N.W. Wash. D.C.   |  | <u>Walter H. H. H.</u>   |  |

404

255

1006 Cassville Rd., ATL., Ga. 30316.

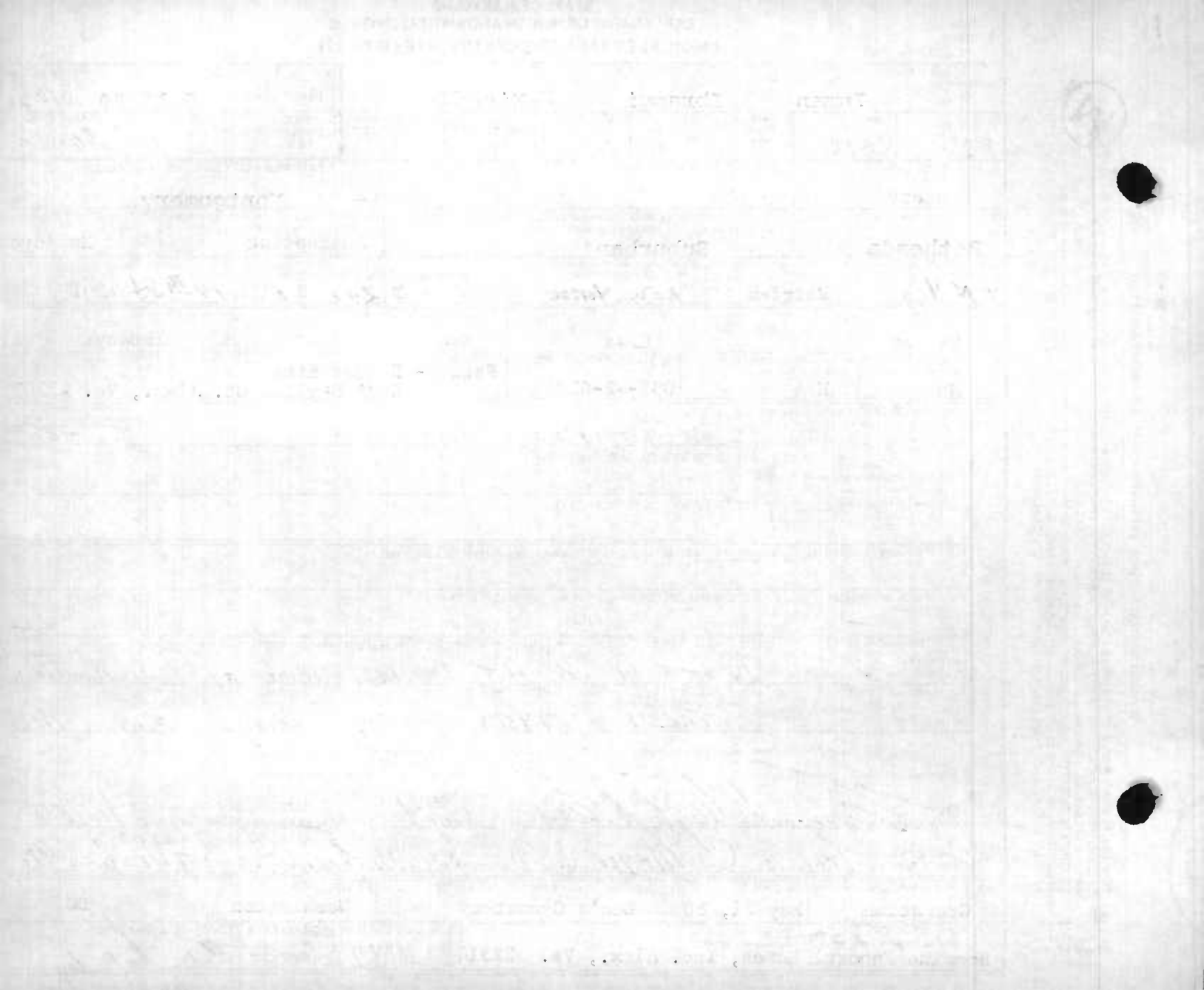
• • • • •

4. 278. 2211 8404



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                     |  |  |   |  |  |   |  | REG. NO. 13300   |  |
|--|--|-------------------------------------|--|--|---|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |                                     |  |  |   |  |  |   |  | 20. DATE KNOWN OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Iman Agnes Ibranyi-Kiss  |  |                                     |  |  |   |  |  |   |  | ESTIMATED MONTH DAY YEAR<br>5 18 80  |  |
| 3. SEX<br>Fe   |  | 4. RACE<br>Cauc                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 15 50   |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>29   |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Hungary   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>5 18 80   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban                                      |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Journalist |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self Employed                               |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                     |  |  |   |  |  |   |  | 12c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |
| 13a. STATE<br>Virginia   |  | 13b. COUNTY<br>Fairfax              |  | 13c. CITY OR TOWN<br>Alexandria  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 13e. STREET ADDRESS<br>6624 Skyline Court 22307                             |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Sandor Kiss   |  |                                     |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Eva Ibranyi |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No N/A   |  |                                     |  | 16b. SOCIAL SECURITY NO.<br>055-42-6301  |   | 17. INFORMANT ADDRESS<br>Father- Sandor Kiss<br>6624 Skyline Ct. Alex., Va. 22307  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MULTIPLE TRAUMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                                     |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>ACUTE                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                                     |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |  |                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>10 5 18 80   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>HIT LEAVING DRIVEWAY (Volkswagen Truck) |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>STREET  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>2431 9 Route 109 Comus MONT. MD  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                                     |  |  |   |  |  |   |  |  |  |
| ACTUAL SIGNATURE Francis C. Mayle Jr. MD   |  |                                     |  |  |   | TITLE (SPECIFY)<br>Deputy  |  | MEDICAL EXAMINER  |  | DATE SIGNED<br>5/18/80   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Francis C. Mayle Jr. MD   |  |                                     |  |  |   | ADDRESS<br>8200 Wisconsin Ave Bethesda MD  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |                                     |  | 23b. DATE<br>May 21, 80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Washington DC                         |  |
| 24. FUNERAL DIRECTOR NAME<br>Wayne J. Reed   |  |                                     |  |  |   | ADDRESS<br>Demaine Funeral Homes, Inc. Alex., Va. 22314  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 26 1980                                |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

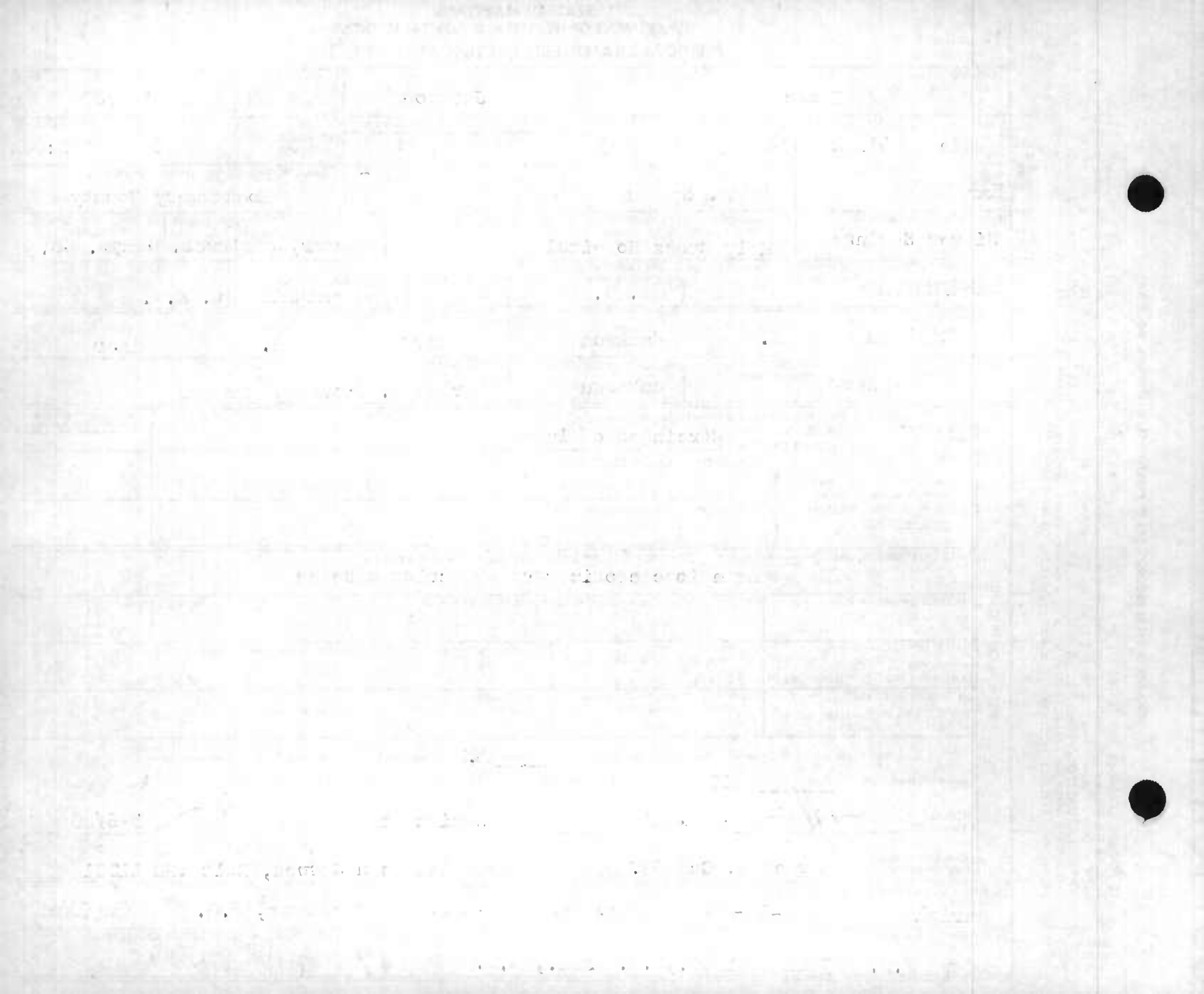


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 8013301   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) Isaac Jackson   |  |  |  |  |  |  |  |  |  | 2b. HOUR M 1980  |  |
| 3. SEX male 4. RACE black 5. DATE OF BIRTH 4 3 07 6. AGE (IN YEARS) 73 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN   |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD 5 6 1980 2d. HOUR 3:00A   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? United States 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.   |  |
| 10. CITY OR TOWN OF DEATH Silver Springs 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer, Construct. 12b. KIND OF BUSINESS OR INDUSTRY Const. Co. |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) WASHINGTON 13b. COUNTY D.C. 13c. CITY OR TOWN D.C. 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 54 Channing St. N.W.   |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME William e Jackson 15. MOTHER'S MAIDEN NAME Mary A. Miner   |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unknown 16b. SOCIAL SECURITY NO. unknown 17. INFORMANT Charles H. Jackson, Brother ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 1659<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic cardiovascular disease   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE [Signature] M.D. Assistant MEDICAL EXAMINER DATE SIGNED 5/6/80  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard M.D. ADDRESS 111 Penn Street, Balto. MD 21201  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 5-10-80 23c. NAME OF CEMETERY OR CREMATORY Harmony CEMETERY 23d. LOCATION CITY OR TOWN P.O. COUNTY Maryland STATE   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME Modern F.H. ADDRESS 3821 14th St., N.W. Wash., D.C. 25a. DATE REC'D. BY REGISTRAR MAY 27 1980 25b. REGISTRAR'S SIGNATURE [Signature]   |  |  |  |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |  |  |  |  |                             |
|--|--|--|--|---|---|--|--|--|--|-----------------------------|
| FOR<br>1. STATE<br>REGISTRAR   |  |  |  |   | REG. NO.  |  |  |  |  |                             |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Percy W. Jarboe</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 19, 1980</b>   |  |  |  |  | 2b. HOUR P<br><b>5:20 M</b> |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 14, 1897</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                |  |  |  |                             |
| 10. CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3319 W. Coguelin Terrace</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Construction</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>D.C. Gov't</b>   |  |                             |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |                             |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Chevy Chase</b>   |   | 13e. STREET ADDRESS<br><b>3319 W. Coguelin Terrace</b>                                       |  |  |  |                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jarboe</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura Boone</b>                             |  |  |  |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI</b>  |  | 17. INFORMANT<br><b>Carolyn Lee Jarboe</b>  |   | ADDRESS<br><b>Same as #13</b>  |  |  |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Meningeal Terebral Hemorrhage</b><br><b>431-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b> |  |  |  |   |   |  |  |  |  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |  |  |  |                             |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |                             |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 10, 1972</b> to <b>May 15, 1980</b> , that (I) (we) last saw the deceased alive on <b>May 15, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |  |  |                             |
| 22b. SIGNATURE<br><b>W.B. Wardrop, M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  |   |   |  |  | 22c. DATE SIGNED<br><b>May 20/80</b>   |  |                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. B. Wardrop, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>8520 Connecticut Ave., Chevy Chase, Md.</b>  |   |  |  |  |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>May 24, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Epiphany Episcopal Cem</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Forestville PG Maryland</b>                 |  |  |  |                             |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert E. Wilhelm</b><br><b>Funeral Home Inc</b>  |  |  |  | ADDRESS<br><b>Suitland, Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 27 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |                             |

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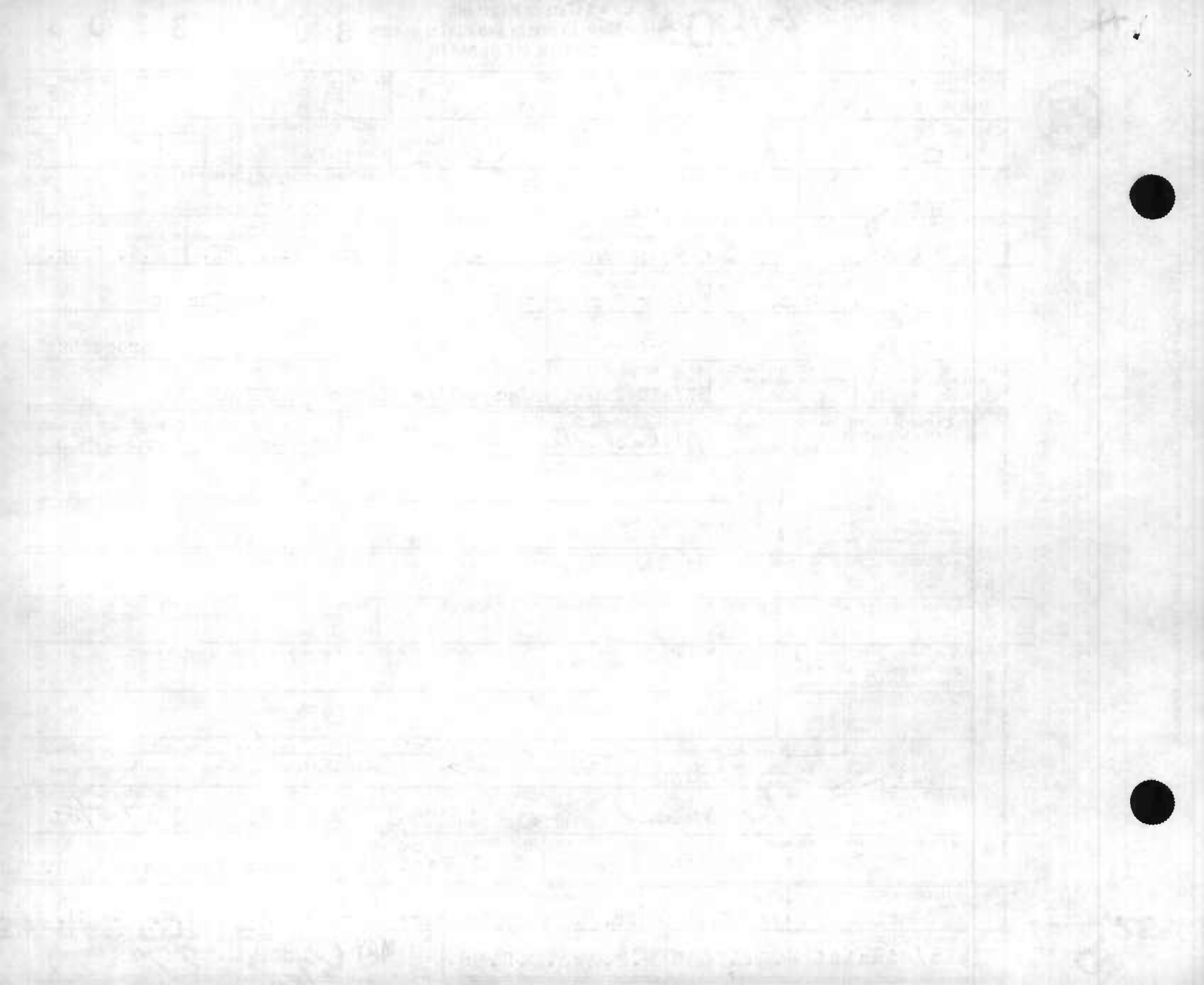
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |  |  |  | 8 0 1 3 3 0 3   |  |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |   |  |  |  | REG. NO.  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Louise F. Johnson</i>  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><i>5/4/80</i>   |  |   |  | 2b HOUR<br><i>3:05 PM</i>  |  |   |  |
| 3 SEX<br><i>F</i>   |  | 4 RACE<br><i>W</i>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><i>2 3 12</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>68</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Penna.</i>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                            |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><i>Bethesda</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Suburban Hosp</i> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Govt. Acct. Off.</i> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><i>U.S. Govt.</i>  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><i>Md.</i>  |  |  |  | 13b COUNTY<br><i>Mont.</i>   |  | 13c CITY OR TOWN<br><i>Silver Spring</i>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br><i>3604 Kayson Street</i>   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><i>James Frisco</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Bertha Waroquier</i>  |  |   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><i>None</i>   |  | 17 INFORMANT<br><i>Jacqueline Dietsch</i>  |  | ADDRESS<br><i>SAME AS #13</i>   |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <i>Metastatic Breast Cancer</i><br><i>1749</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>months</i>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION   |  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>19</i>   |  |   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <i>5/4/80</i> to <i>5/4/80</i> , that (I) (we) last saw the deceased alive on <i>5/4/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |   |  |
| 22b SIGNATURE<br><i>Stephen Newman</i>  |  |  |  | DEGREE<br><i>MD</i>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><i>5/5/80</i>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Stephen Newman</i>   |  |  |  | 22e ADDRESS<br><i>5411 West Cedar Lane Bethesda, MD.</i>   |  |   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b DATE<br><i>May 7, 1980</i>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><i>Ft. Lincoln Cemetery</i>   |  | 23d LOCATION CITY OR TOWN<br><i>Brentwood</i>   |  | COUNTY<br><i>P.G.</i>  |  | STATE<br><i>Md.</i>   |  |
| 24 FUNERAL DIRECTOR<br><i>Hine's/Rinaldi</i>  |  |  |  | ADDRESS<br><i>F.H.11800 N.H.Ave.S.S.Md.</i>  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br><i>MAY 7 1980</i>  |  | 25b REGISTRAR'S SIGNATURE<br><i>Hofrey/McBryde</i>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 1 3 3 0 4  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1 - FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |   |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a DATE OF DEATH   |  |   |   |
| FIRST MIDDLE LAST<br><b>Minnie Evond Johnson</b>  |  |   |  | MONTH DAY YEAR<br><b>May 17 80</b>   |  |   |   |
| 3 SEX   |  |   |  | 2b HOUR  |  |   |   |
| <b>Female</b>   |  |   |  | <b>5:30A M</b>   |  |   |   |
| 4 RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR  |   |
| <b>White</b>  |  | MONTH DAY YEAR<br><b>Dec 28 1921</b>  |  | <b>58</b>  |  | MONTHS DAYS HOURS MIN   |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |   |
| <b>Maryland</b>   |  | <b>USA</b>  |  |  |  | <b>Montgomery County MD</b>   |   |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |   |
| <b>Silver Spring</b>  |  | <b>610 Rosemere Drive</b>   |  | <b>Childcare</b>   |  | <b>Daycare</b>  |   |
| 13a STATE   |  | 13b COUNTY  |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?   |   |
| <b>Maryland</b>   |  | <b>Montgomery</b>   |  | <b>S.S.</b>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14 FATHER'S NAME  |  | 15 MOTHER'S MAIDEN NAME   |  | 13e STREET ADDRESS   |  |   |   |
| FIRST MIDDLE LAST<br><b>Clarence I Queen (Dec)</b>  |  | FIRST MIDDLE LAST<br><b>Katie Groves (Dec)</b>  |  | <b>610 Rosemere Drive</b>  |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO  |  | 17 INFORMANT   |  | ADDRESS   |   |
| <b>No</b>   |  | <b>218-16-0348</b>  |  | <b>Charles F. Johnson,</b>   |  | <b>-same</b>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>   |  |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 Hours</b> |
| 410-<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST<br>(b) <b>Coronary Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |  |  |   | <b>10 Years</b>   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |   |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?   |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?    |   |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |
| 21a ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22 I certify that (I) (this hospital) attended the deceased from <b>March 10, 1980</b> to <b>May 17, 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>March 10, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |   |
| 22b SIGNATURE<br><i>Arthur S. Bresler</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c DATE SIGNED<br><i>May 17, 1980</i>                              |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur S. Bresler</b>  |  |   |  | 22e ADDRESS<br><b>Lockwood Dr. Silver Spring, Maryland</b>   |  |   |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                           |   |
| <b>Burial</b>   |  | <b>May 20, 1980</b>   |  | <b>Colesville Cemetery</b>   |  | <b>Colesville Mont Maryland</b>                                     |   |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  | 25 DATE REC'D BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE   |   |
| <b>Francis H. Barber Laytonsville, Maryland 20760</b>   |  |   |  | <b>MAY 22 1980</b>   |  | <i>[Signature]</i>  |   |



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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

70 13305

|   |  |  |  |   |   |  |
|---|--|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Reuben nmn Johnson</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05/18/80</b> |   | 2b. HOUR<br><b>3:35</b> <sup>a</sup>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 21, 1910</b>  |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 7. IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  | 10. CITY OR TOWN OF DEATH<br><b>Olney, Md.</b>                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b>             |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Montg.</b>   |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>14615 Avery Road</b>                           |  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Will Johnson</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>          |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>422-09-6745</b>                           |  | 17. INFORMANT<br>ADDRESS<br><b>Eddie D. Johnson (Wife) same as #13</b>  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory failure</b><br><b>0389</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Septic</b> |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs</b><br><b>24 hrs</b><br><b>48 hrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Renal failure</b>   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/15/80</b> 19 to <b>5/18/80</b> 19, that (I) (we) last saw the deceased alive on <b>5/17</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.  |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE<br><b>[Signature]</b>   |  | 22c. DATE SIGNED<br><b>5/18/80</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. Croft</b>  |  | 22e. ADDRESS<br><b>106 W. Fox Ave SS Mt</b>                              |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-23-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cem.</b>  |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring, Montg. Md.</b>  |  |  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George R. Snowden</b>  |  | 24b. ADDRESS<br><b>246 N. Washington Street<br/>Rockville, Md. 20850</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 22 1980</b>   |   |  |

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VE-ES-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8013306

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |   |  |   |  |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>M SYLVIA JOHNSTON   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 23 80                         |   |  | 2b. HOUR<br>9:15 P.M.  |   |  |   |  |
| 3. SEX<br>F  |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 07 23   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 76 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>W VA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>SILVER SPRING   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLY CROSS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DAY WORKER   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Domestic  |   |  |
| 13a. STATE<br>MD   |  |  | 13b. COUNTY<br>MO  |   | 13c. CITY OR TOWN<br>SILVER SPRING                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2302 GLENMONT CIR #101 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jasper Jones   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Belle Downs      |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>333-72-9949                                |   | 17. INFORMANT<br>ADDRESS<br>Martha Anderson Same (n) 13E |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>WITH MULTIPLE MYOCARDIAL INFARCTS</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>TWO WEEKS</u>  |  |  |  |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>DIABETIS MELLITUS</u>   |  |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>19 65</u> to <u>23 MAY 19 80</u> , that (I) <u>did</u> <input checked="" type="checkbox"/> <u>saw</u> the deceased alive on <u>23 MAY 19 80</u> , and that in (my) <u>own</u> <input checked="" type="checkbox"/> <u>apinion</u> death occurred on the date and hour and from the causes stated above, (I) <u>did</u> <input checked="" type="checkbox"/> <u>did not</u> <input type="checkbox"/> view the body after death. |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Walter E. Goozner</u>   |  |  | DEGREE<br><u>MD</u>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>24 May 80</u>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER E. GOOZNER MD  |  |  | 22e. ADDRESS<br>2309 SHOREFIELD RD WHEATON MD                          |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  |  | 23b. DATE<br>5-26-80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Odd Fellows        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Prince Georges W. Va                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. W. Chambers   |  |  | ADDRESS<br>8655 Rowaness, Md   |   |  | 25. JURY REC'D. BY REGISTRAR   |   | 26. REGISTRAR'S SIGNATURE  |   |  |



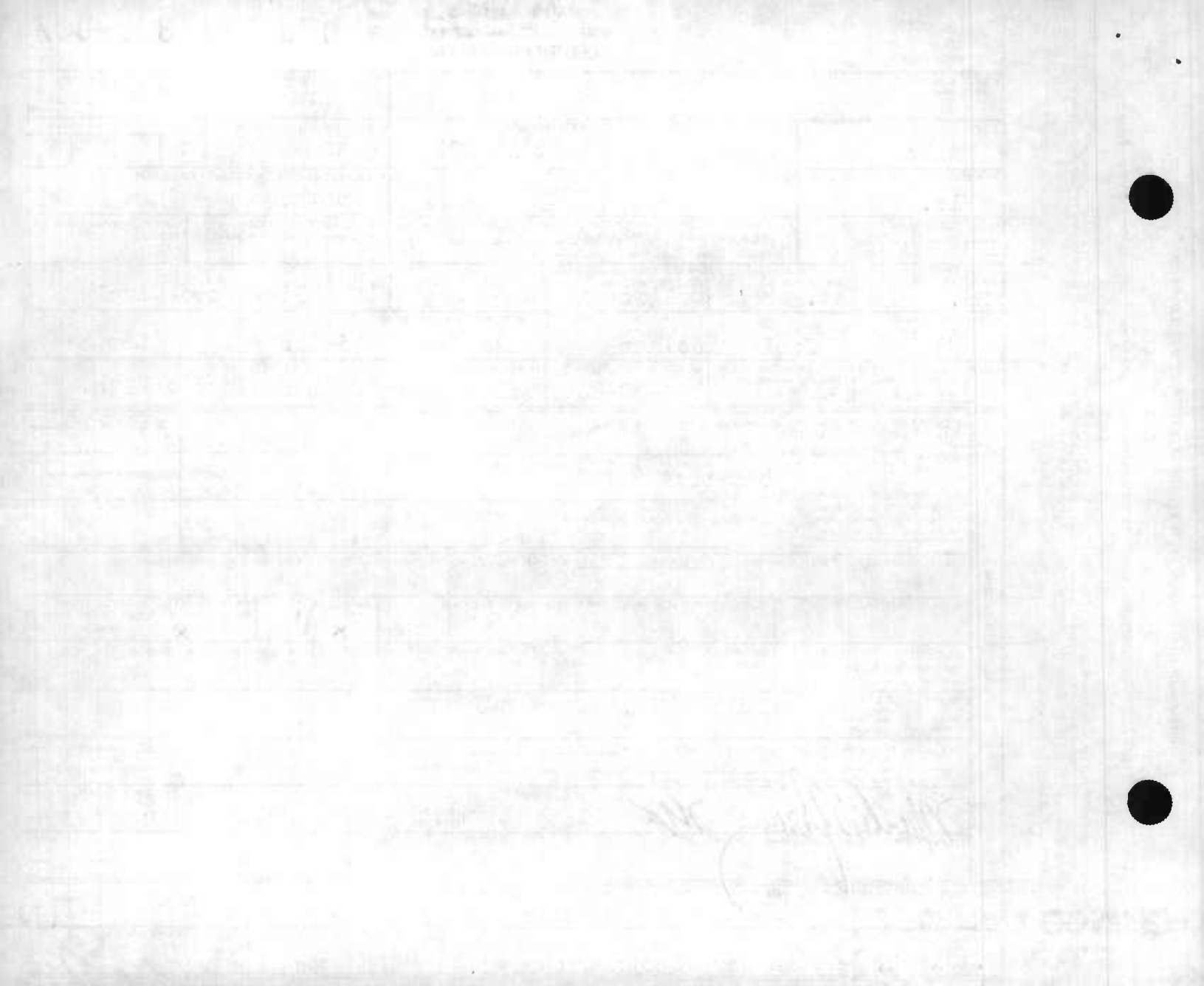


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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |                     | 8013307            |  |
|---|--|--|--|--|--|--|--|---|---------------------|--------------------|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  |  |  |  |   |                     | REG. NO.           |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>MILLARD LOREZ JOINER  |  |  |  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 04, 1980   |  |   | 2b HOUR<br>01.05 AM |                    |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept 12, 1927   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                     | 8 IF UNDER 24 HRS. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Fla.  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |   |                     |                    |  |
| 10 CITY OR TOWN OF DEATH<br>BETHESDA, MD  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NATIONAL NAVAL MEDICAL CENTER |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                     |                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.   |  | 13b. COUNTY<br>St. Mary's  |  | 13c. CITY OR TOWN<br>California  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>700 Pine Wood Circle   |                     |                    |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Millard Joel Joiner  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Clifford Vivian Lee   |  |   |                     |                    |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>435-30-8606   |  | 17 INFORMANT ADDRESS<br>Aileen Mary Joiner Same as 13e.  |  |  |  |   |                     |                    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) PNEUMONIA<br>5728<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) HEPATIC FAILURE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |   |                     |                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |   |                     |                    |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                     |                    |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |                     |                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |                     |                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 26 MAR 19 80 to 04 MAY 19 80, that (I) (we) last saw the deceased alive on 04 MAY 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |                     |                    |  |
| 22b. SIGNATURE<br>M.D. BROWNING, MC, USN  |  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>04 MAY 80   |                     |                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  | 22e. ADDRESS<br>NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD  |  |   |                     |                    |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5/8/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Memorial  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Orlando Fla.   |  |   |                     |                    |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>W. Clarke Mattingley Leonardtown, Md.  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 8 1980  |  | 25b. REGISTRAR'S SIGNATURE  |                     |                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |  |  |  |   |  |  |
|--|---|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR  |  |  |
| FIRST MIDDLE LAST<br><i>Estelle Louise Jones</i>   |   |   | MONTH DAY YEAR<br><i>5. 12. 80</i>                               |  |  | HOUR MIN.<br><i>8<sup>05</sup> M</i>                                |  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  |  | 7. UNDER 1 YEAR   |  |  |
| <i>Female</i>  | <i>Black</i>  | MONTH DAY YEAR<br><i>6 10 35</i>  | <i>44</i>  |  |  | MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |  |   |  |  |
| <i>Maryland</i>  | <i>USA</i>  |   | <i>Montgomery County MD.</i>                                     |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| <i>Takoma Park, Md.</i>  | <i>Washington Adventist Hospital</i>  |   | <i>Homemaker.</i>  |  |  |   |  |  |
| 13a. USUAL RESIDENCE (IF ADDRESS HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   | 13b. INSIDE CITY LIMITS?  | 13c. STREET ADDRESS  |  |  |   |  |  |
| 13a. STATE 13b. COUNTY<br><i>Washington D. C.</i>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  | <i>623 Whittier St. N. W.</i>                                    |  |  |   |  |  |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME  |  | 16. ADDRESS  |  |   |  |  |
| FIRST MIDDLE LAST<br><i>Adolf Dawes</i>  |   | FIRST MIDDLE LAST<br><i>Alberta Washington</i>  |  | <i>13 (e)</i>  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |   |  |  |
| <i>No.</i>   |   |   |  | <i>Benjamin W. Jones, (Husband)</i>  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Malignant</i><br><i>1539</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <i>Wide spread Metastases</i><br>(c) <i>Carcinoma of Colon</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |   |   |  |  |  |   |  | SPECIFICATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |   |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |
| <i>3/3/4</i>   |   | <i>Intestinal Obst.</i>   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-12/80</i> 19 <i>80</i> to <i>5/12/80</i> 19 <i>80</i> that (I) (we) last saw the deceased alive on <i>5-12/80</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above.   |   | 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22c. ADDRESS  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |  |
| <i>H. L. MARTER</i>  |   | <i>531 University Blvd East Silver Spring Md.</i>   |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |
| <i>Burial</i>  |   | <i>May 15, 1980</i>   |  | <i>National Mem. Park, P. Geo. Co. Md</i>  |  |   |  |  |
| 24. FUNERAL DIRECTOR   |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |
| <i>Arthur Walter</i>   |   | <i>250 Carroll St. N.W. Washington D.C. 20036</i>   |  | <i>MAY 16 1980</i>   |  | <i>Jeffrey McCreary</i>   |  |  |

BP



November.

1913 November 21. M. W.

Washington D. C.

1913

13 (4)  
September 11. Jones. (Hunting)

1913



Nov 13, 1913. National Park, D. C. Co. 21.

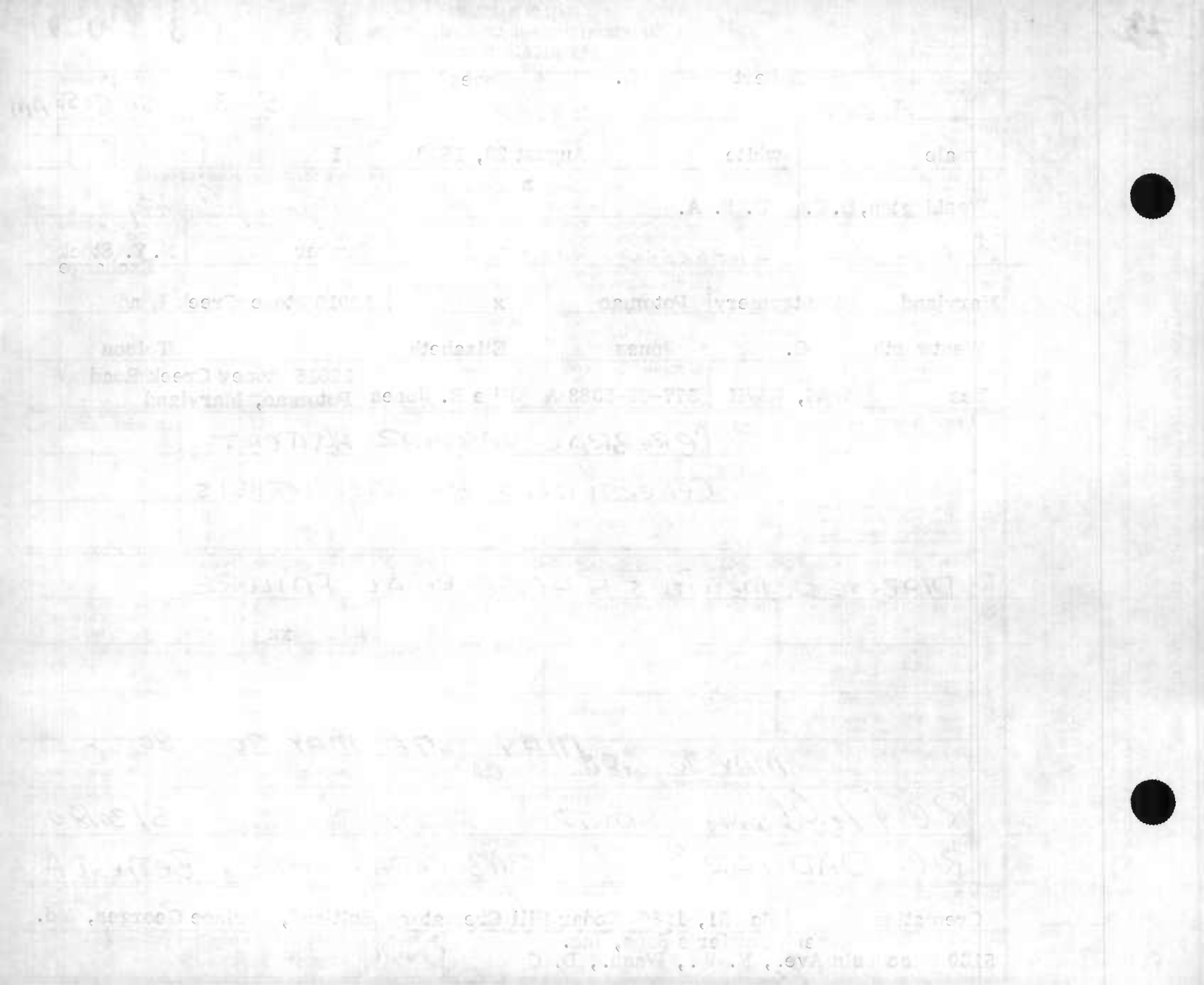
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 3. REG. NO.  |  | 4. DECEASED NAME (TYPE OR PRINT)                                    |  | 5. DECEASED NAME (FIRST, MIDDLE, LAST)                              |  |
|   |  | 5-30-80  |  | 8:58 AM  |  | ROBERT JONES  |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR  |  |
| male  |  | white  |  | August 23, 1898  |  | 81  |  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 10. IF UNDER 24 HRS   |  |
| Washington, D. C.   |  | U. S. A.   |  |  |  | Montgomery County   |  |   |  |
| 11. CITY OR TOWN OF DEATH   |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 14. KIND OF BUSINESS OR INDUSTRY                                    |  | 15. BALTIMORE CITY OR COUNTY OF DEATH                               |  |
| Bethesda, Md.   |  | SUBURBAN Hospital  |  | Broker   |  | N. Y. Stock Exchange  |  |   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 17. STATE  |  | 18. COUNTY   |  | 19. CITY OR TOWN  |  | 20. INSIDE CITY LIMITS?   |  |
| Maryland  |  | Montgomery   |  | Potomac  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21. FATHER'S NAME (FIRST, MIDDLE, LAST)   |  | 22. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST)   |  | 23. STREET ADDRESS   |  | 24. ADDRESS   |  | 25. ADDRESS   |  |
| Wentworth C. Jones  |  | Elizabeth Tolson   |  | 12015 Stoney Creek Road  |  | Potomac, Maryland   |  |   |  |
| 26. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 27. SOCIAL SECURITY NO.  |  | 28. INFORMANT  |  | 29. ADDRESS   |  | 30. ADDRESS   |  |
| Yes   |  | WWI, WWII  |  | 577-09-5383 A  |  | Jille R. Jones  |  | 12015 Stoney Creek Road   |  |
| 31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 32. PART I. DEATH WAS CAUSED BY:   |  | 33. IMMEDIATE CAUSE (a)  |  | 34. DUE TO, OR AS A CONSEQUENCE OF                                  |  | 35. DUE TO, OR AS A CONSEQUENCE OF                                  |  |
| 436-  |  | CEREBRAL VASCULAR ACCIDENT   |  |  |  | GENERALIZED ARTERIOSCLEROSIS  |  |   |  |
| 36. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST   |  | 37. DUE TO, OR AS A CONSEQUENCE OF   |  | 38. DUE TO, OR AS A CONSEQUENCE OF   |  | 39. DUE TO, OR AS A CONSEQUENCE OF                                  |  | 40. DUE TO, OR AS A CONSEQUENCE OF                                  |  |
|   |  |  |  |  |  |   |  |   |  |
| 41. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)            |  | 42. DATE OF OPERATION  |  | 43. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 44. AUTOPSY?  |  | 45. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |  |
| DIABETES MELLITUS & ACUTE RENAL FAILURE   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 46. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 47. TIME OF INJURY   |  | 48. HOW INJURY OCCURRED  |  | 49. LOCATION  |  | 50. CITY OR TOWN  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | CITY OR TOWN  |  | COUNTY  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | STREET   |  | CITY OR TOWN  |  | COUNTY  |  |
| 21g. I certify that (I) (this hospital) attended the deceased from  |  | 21h. DATE OF DEATH   |  | 21i. DATE OF DEATH   |  | 21j. DATE OF DEATH  |  | 21k. DATE OF DEATH  |  |
| MAY 30 1980   |  | MAY 30 1980  |  | MAY 30 1980  |  | MAY 30 1980   |  | MAY 30 1980   |  |
| 21l. SIGNATURE  |  | 21m. DEGREE  |  | 21n. DATE SIGNED   |  | 21o. DATE SIGNED  |  | 21p. DATE SIGNED  |  |
| R.C. Daddario M.D.  |  |  |  | 5/30/80  |  |   |  |   |  |
| 21q. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 21r. ADDRESS   |  | 21s. DATE SIGNED   |  | 21t. REGISTRAR'S SIGNATURE  |  | 21u. REGISTRAR'S SIGNATURE  |  |
| R.C. DADDARIO   |  | 5413 CEDAR LANE BETHESDA   |  | JUN 6 1980   |  |   |  |   |  |
| 22. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23. DATE   |  | 24. NAME OF CEMETERY OR CREMATORY  |  | 25. LOCATION  |  | 26. COUNTY  |  |
| Cremation   |  | May 31, 1980   |  | Cedar Hill Crematory   |  | Suitland, Prince Georges, Md.                                       |  |   |  |
| 27. FUNERAL DIRECTOR  |  | 28. NAME   |  | 29. ADDRESS  |  | 30. DATE SIGNED   |  | 31. REGISTRAR'S SIGNATURE   |  |
| Joseph Gawler's Sons, Inc.  |  | 5130 Wisconsin Ave., N. W., Wash., D. C.   |  |  |  | JUN 6 1980  |  |   |  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 1 3 3 1 0   |          |
|---|--|---|--|---|----------|
| 1. FOR STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |          |
| FIRST MIDDLE LAST   |  |   |  | MONTH DAY YEAR  | 2b. HOUR |
| Jacqueline J. JORDAN  |  |   |  | May 9 1980  | 1250A M  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |          |
| Female  |  | Caucasian   |  | MONTH DAY YEAR  |          |
|   |  |   |  | Sept, 3 1962  |          |
| 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. CITIZEN OF WHAT COUNTRY?   |  | 8. BALTIMORE CITY OR COUNTY OF DEATH  |          |
| 17 YRS.   |  | USA   |  | Montgomery MD.  |          |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION   |          |
| Indiana   |  | Bethesda  |  | National Naval Medical Center   |          |
| 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 13. KIND OF BUSINESS OR INDUSTRY                                    |  | 14. FATHER'S NAME   |          |
| Student   |  |   |  | FIRST MIDDLE LAST   |          |
|   |  |   |  | Bill Jordan   |          |
| 15. MOTHER'S MAIDEN NAME  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)    |  | 17. INFORMANT ADDRESS   |          |
| Patricia Carter   |  | Mo  |  | Bill Jordan See item 13   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 19. SOCIAL SECURITY NO.   |  | 20. DATE OF OPERATION   |          |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute leukemia</u>   |  | None  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |          |
| 2080  |  |   |  | 20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |          |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  | 20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |   |          |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |          |
|   |  | P.M. 19   |  |   |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |          |
|   |  |   |  |   |          |
| 22a. I certify that (I (this hospital) attended the deceased from May 5, 1980, to May 9, 1980, that (I/(we) lost saw the deceased alive on May 9, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/(we) (did) (did not) view the body after death. |  | 22b. SIGNATURE  |  | 22c. DATE SIGNED  |          |
|   |  | J. J. ROCHE, M.D.   |  | May 9, 1980   |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |          |
| Burial  |  | 5/12/80   |  | Arlington National  |          |
| 24. FUNERAL DIRECTOR NAME   |  | 25. ADDRESS   |  | 26. LOCATION CITY OR TOWN COUNTY STATE  |          |
| Hines- Rinaldi Funeral Home Silver Spring, Md   |  | 11800 N.H. Ave  |  | Arlington National Va.  |          |
| 27. DATE REC'D. BY REGISTRAR  |  | 28. REGISTRAR'S SIGNATURE   |  | 29. REGISTRAR'S SIGNATURE   |          |
| MAY 13 1980   |  |   |  |   |          |



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20 June 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |   |  | 8 0 1 3 3 1 1   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  |   |  |  |  |   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>JAMES Franklin JORDAN</b>  |  |  |  |   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 16 1980</b>   |  |
| 3. SEX <b>MALE</b>   |  |  |  |   |  |  |  |   |  | 2b. HOUR <b>2:35 PM</b>   |  |
| 4. RACE <b>Cauc.</b>   |  |  |  |   |  |  |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR <b>11 17 1890</b>  |  |  |  |   |  |  |  |   |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Amoy, China</b>   |  |  |  |   |  |  |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>   |  |
| 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  |   |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Executive</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |   |  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Mobile Oil</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>Olney MD</b>  |  |  |  |   |  |  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sharon NURSING HOME</b> |  |
| 13a. STATE <b>MD</b>   |  |  |  |   |  |  |  |   |  | 13b. COUNTY <b>Bethesda</b>   |  |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |  |  |   |  | 13d. STREET ADDRESS <b>7545 Spring Lake Dr. Bethesda, Md.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Augie ADGE</b>  |  |  |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Christina Unknown</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  |   |  |  |  |   |  | 16b. SOCIAL SECURITY NO. <b>220-44-5357</b>   |  |
| 17. INFORMANT <b>Svend E. Jordan</b>   |  |  |  |   |  |  |  |   |  | ADDRESS <b>7545 Spring Lake Dr. Bethesda, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4375</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>General debilitation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Organic brain syndrome</b> |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>—   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |   |  |
| MEDICAL CERTIFICATION  |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>         |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 78</b> to <b>May 1980</b> , that (I) (we) lost saw the deceased alive on <b>May 9 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Albert S. Whiting</b> DEGREE <b>MD</b>   |  |  |  |   |  |  |  |   |  | 22c. DATE SIGNED <b>May 16 1980</b>   |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Albert S. Whiting</b>   |  |  |  |   |  |  |  |   |  | 22b. ADDRESS <b>3933 Oaklawn Rd Laurel MD</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  |  |  | 23b. DATE <b>May 17 1980</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lee Funeral Home</b>                        |  |   |  |
| 23d. LOCATION CITY OR TOWN <b>Washington</b>   |  |  |  | COUNTY <b>D.C.</b>  |  |  |  | STATE   |  |   |  |
| 24. FUNERAL DIRECTOR <b>Francis H. Barber</b> ADDRESS <b>Laytonsville, Md.</b>   |  |  |  |   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 21 1980</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Francis H. Barber</b>  |  |  |  |   |  |  |  |   |  |   |  |

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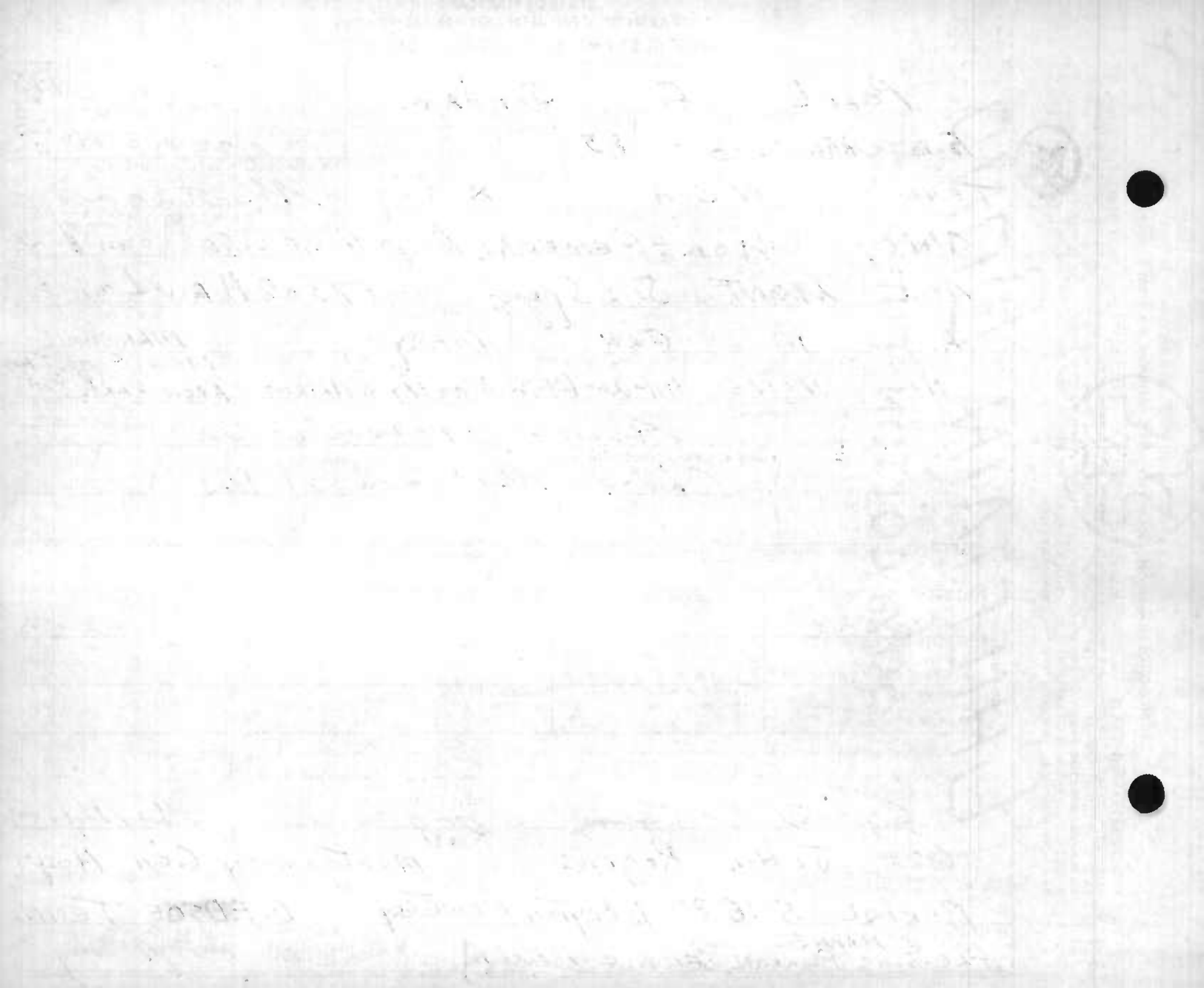
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |   |   |  |                                    |   |                  |                                   |   | REG. NO. 13312                               |            |
|--|---------|---|---|--|------------------------------------|---|------------------|-----------------------------------|---|--|------------|
| 1- STATE REGISTRAR   |         |   |   |  |                                    |   |                  |                                   |   |  |            |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |   | FIRST   |  | MIDDLE                             |   | LAST             |                                   | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR   |
| Pearl G. Jordan  |         |   |   |  |                                    |   |                  |                                   | MAY 12 1980   |  | 1:00 PM    |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS)  | IF UNDER 1 YR.                     |   | IF UNDER 24 HRS. |                                   | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR   |
| FEMALE   | WHITE   | OCT 8-94  |   | 85 YRS.  |                                    |   |                  |                                   | MAY 12 1980   |  | 2:00 PM    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                  |                                   |   |  |            |
| TENN.  |         | U.S.A.  |   |  |                                    | Montgomery MD.  |                  |                                   |   |  |            |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |            |
| Olmley   |         | MONTGOMERY HOSP   |   |  |                                    | HOUSEWIFE   |                  | OWN HOME                          |   |  |            |
| 13a. STATE   |         | 13b. COUNTY   |   | 13c. CITY OR TOWN  |                                    | 13d. INSIDE CITY LIMITS   |                  | 13e. STREET ADDRESS               |   |  |            |
| MD   |         | MONTG.  |   | St. L. Springs   |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                  | 17308 HAWLANE                     |   |  |            |
| 14. FATHER'S NAME  |         |   | 15. MOTHER'S MAIDEN NAME                                    |  |                                    |   |                  |                                   |   |  |            |
| FIRST MIDDLE LAST  |         |   | FIRST MIDDLE LAST   |  |                                    |   |                  |                                   |   |  |            |
| A. M. GAW  |         |   | MARY MARSHALL   |  |                                    |   |                  |                                   |   |  |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |   | 16b. SOCIAL SECURITY NO.                                    |  |                                    | 17. INFORMANT   |                  |                                   | ADDRESS   |  |            |
| NO   |         |   | NONE  |  |                                    | 41-20-6946  |                  |                                   | JOHN RAY WILLIAMS 140 N. FOREST AVE. AVON PARK, FLA                 |  |            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Myocardial Dns.<br>4291<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) Chronic Myocardial Dns.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |   |   |  |                                    |   |                  |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |   |   |  |                                    |   |                  |                                   |   |  |            |
| None   |         |   |   |  |                                    |   |                  |                                   |   |  |            |
| 19a. DATE OF OPERATION   |         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                                    |   |                  |                                   | 20. AUTOPSY?  |  |            |
| None   |         |   |   |  |                                    |   |                  |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |            |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                  |                                   |   |  |            |
|  |         |   | P.M. 19   |  |                                    |   |                  |                                   |   |  |            |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                                    | 21f. LOCATION CITY OR TOWN COUNTY STATE                                       |                  |                                   |   |  |            |
|  |         |   |   |  |                                    |   |                  |                                   |   |  |            |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |   |  |                                    |   |                  |                                   |   |  |            |
| ACTUAL SIGNATURE   |         |   | TITLE (SPECIFY)   |  |                                    | M.D.  |                  |                                   | MEDICAL EXAMINER  |  |            |
| JOHN ROGERS  |         |   | DOP   |  |                                    |   |                  |                                   | MAY 12 1980   |  |            |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |   | ADDRESS   |  |                                    | MONTGOMERY GEN. HOSP.   |                  |                                   |   |  |            |
| JOHN ROGERS  |         |   |   |  |                                    |   |                  |                                   |   |  |            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |   |                  | 23d. LOCATION CITY OR TOWN        |   |  | 23e. STATE |
| BURIAL   |         |   | 5-16-80   |  | BRAYTON CEMETERY                   |   |                  | BLADES                            |   |  | TENN.      |
| 24. FUNERAL DIRECTOR NAME  |         |   | ADDRESS   |  |                                    | 25a. DATE REC'D. BY REGISTRAR   |                  |                                   | 25b. REGISTRAR'S SIGNATURE  |  |            |
| E BARNES   |         |   | FLEMING FUNERAL SERVICE BENSON                              |  |                                    | MAY 19 1980   |                  |                                   | History McCreedy  |  |            |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 0 1 3 3 1 3   |  |  |  |   |  |  |  |                 |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|-----------------|--|--|--|
| 1. STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |   |  |  |  |   |  |  |  |                 |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |  |  | FIRST MIDDLE LAST   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  | 2b. HOUR  |  |  |  |                 |  |  |  |
| Bordie  |  |  |  | Kaufman   |  |  |  | 5-11-80   |  |  |  | 1:25 P.M.   |  |  |  |                 |  |  |  |
| 3 SEX   |  |  |  | 4 RACE  |  |  |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  |  |  |                 |  |  |  |
| Female  |  |  |  | Caucasian   |  |  |  | June 23, 1893   |  |  |  | 86 YRS.   |  |  |  |                 |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  | 7b CITIZEN OF WHAT COUNTRY?   |  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |                 |  |  |  |
| New York  |  |  |  | U.S.A.  |  |  |  |   |  |  |  | Montgomery MD.  |  |  |  |                 |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                          |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |  |                 |  |  |  |
| Silver Spring   |  |  |  | Holy Cross Hospital   |  |  |  | Housewife   |  |  |  | Own Home  |  |  |  |                 |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13a STATE   |  |  |  | 13b COUNTY  |  |  |  | 13c CITY OR TOWN  |  |  |  |                 |  |  |  |
| Maryland  |  |  |  | Montgomery  |  |  |  | Rockville   |  |  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |  |  |                 |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b SOCIAL SECURITY NO.   |  |  |  |                 |  |  |  |
| Meyer   |  |  |  | Solomon   |  |  |  | Unknown   |  |  |  | No  |  |  |  |                 |  |  |  |
| 17 INFORMANT ADDRESS  |  |  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |  |  |                 |  |  |  |
| 12639 Georgia Ave.  |  |  |  | 4029 Acute Congestive Heart Failure   |  |  |  | 24 HRS.   |  |  |  |   |  |  |  |                 |  |  |  |
|   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Distress Syndrome  |  |  |  | 24 HRS.   |  |  |  |   |  |  |  |                 |  |  |  |
|   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiac Vascular Disease  |  |  |  | 15 YRS  |  |  |  |   |  |  |  |                 |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |                 |  |  |  |
| 19a DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                 |  |  |  |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |                 |  |  |  |
|   |  |  |  | P.M. 19   |  |  |  |   |  |  |  |   |  |  |  |                 |  |  |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |                 |  |  |  |
|   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |                 |  |  |  |
| 22a I certify that (I) (the hospital) attended the deceased from 1976, 19, to 5/11/80, 19, that (I) (we) last saw the deceased alive on 5/11/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  | 22b SIGNATURE DEGREE  |  |  |  | 22c DATE SIGNED |  |  |  |
| Lawrence J. Thomas - M.D.   |  |  |  | M.D.  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |  |  | 5/11/80   |  |  |  |                 |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e ADDRESS   |  |  |  | 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b DATE  |  |  |  |                 |  |  |  |
| LAWRENCE J. THOMAS  |  |  |  | 11801 ROCKVILLE PIKE  |  |  |  | Burial  |  |  |  | May 13, 1980  |  |  |  |                 |  |  |  |
| 23c NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d LOCATION CITY OR TOWN COUNTY STATE  |  |  |  | 24 FUNERAL DIRECTOR NAME ADDRESS  |  |  |  | 25a DATE RECD. BY REGISTRAR 25b REGISTRAR'S SIGNATURE   |  |  |  |                 |  |  |  |
| King David Cem  |  |  |  | Falls Church Fairfax Va.  |  |  |  | ROCKVILLE MD.   |  |  |  | MAY 13 1980   |  |  |  |                 |  |  |  |
| DANZANSKY-GOLDBERG CHAPELS  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |                 |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IF PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                  |  |   |  |  |  |  |  | REG. NO. 13314  |  |
|--|--|----------------------------------|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John W. Kefauver</b>  |  |                                  |  |   |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>5 24 1980</b>   |  | 2b. HOUR <b>12:30</b>  |  | 2c. DATE PRONOUNCED DEAD <b>5 24 1980</b>                         |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>white</b>             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>May 13 1955</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>25 YRS</b>  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS. MONTH DAY YEAR                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>  |  |                                  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD. |  |
| 10. CITY OR TOWN OF DEATH <b>Takoma Pk.</b>  |  |                                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Roofer</b>                   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                  |  |   |  | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13b. STREET ADDRESS <b>1801 Jasmine Terr.</b>  |  |   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Prince George</b> |  | 13c. CITY OR TOWN <b>Adelphi</b>  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>David F Kefauver</b>   |  |                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Margaret M Ball</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |                                  |  | 16b. SOCIAL SECURITY NO. <b>213-58-6122</b>   |  | 17. INFORMANT <b>Allyson B Kefauver, Wife.</b>   |  | ADDRESS <b>Same as item 13.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Electrocution</b><br><b>9258</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                                  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                                  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>12:15PM 5-24 1980</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subj. holding onto an aluminum ladder which struck high voltage line</b> |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>bldg.</b>  |  | 21f. STREET <b>300 Elm Street</b>  |  | CITY OR TOWN <b>Takoma Pk.,</b>  |  | COUNTY <b>Maryland</b> STATE                                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                  |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Margaret Mithrell</b>  |  |                                  |  | TITLE (SPECIFY) <b>Assistant</b>  |  |  |  | M.D. <b>Medical Examiner</b>   |  | DATE SIGNED <b>5-25-80</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                                  |  | ADDRESS <b>111 Penn Street</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                                  |  | 23b. DATE <b>5/28/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Maryland</b> STATE  |  |   |  |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>   |  |                                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 2 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| NAME <b>15130 Wisconsin Ave., NW</b> ADDRESS <b>Washington, D.C. 20016</b>   |  |                                  |  |   |  |  |  |  |  |   |  |

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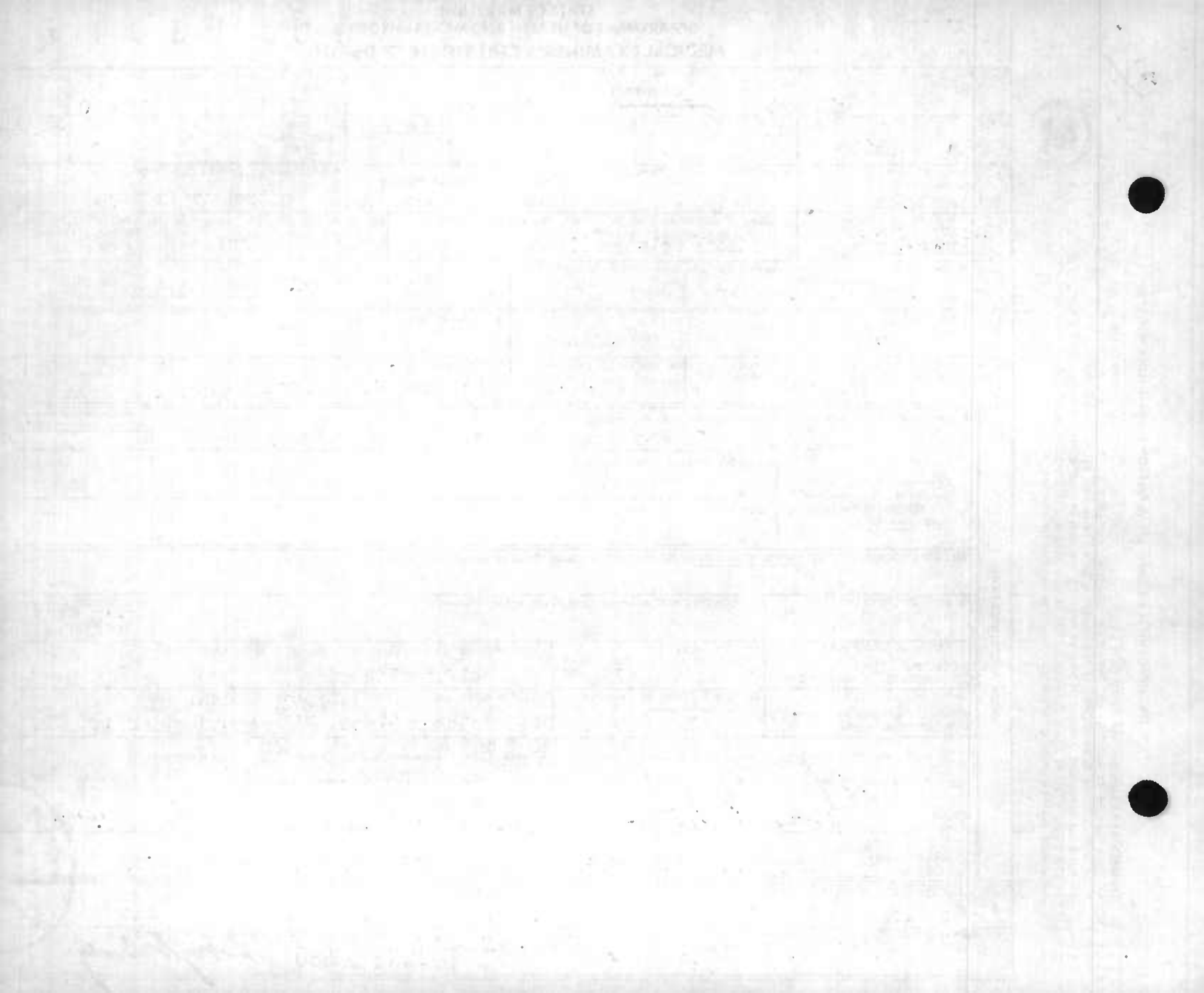
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| #1, Film G545 7/2/80 kam   |  |         |  |  |   |                   |  |  |  | STATE OF MARYLAND  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|--|--|---------|--|--|---|-------------------|--|--|--|--|--|--------------------------------------|--|----------|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| FOR<br>1- STATE REGISTRAR  |  |         |  |  |   |                   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  |  |   |                   |  |  |  | 2a. DATE KNOWN OF DEATH  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST<br>Gilbert Joseph Jerome Kemper  |  |         |  |  |   |                   |  |  |  | MONTH DAY YEAR HOUR<br>5 15 19 80  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.   |  | 2c. DATE PRONOUNCED DEAD             |  | 2b. HOUR |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Male   |  | White   |  | 4 25 1927  |   | 53 YRS.           |  |  |  |  |  | 6 3 19 80                            |  | 10:35A   |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?                             |   |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Minnesota  |  |         |  | USA  |   |                   |  |  |  |  |  | Montgomery County, MD.               |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |   |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Chevy Chase  |  |         |  | 8201 Colston Place                                       |   |                   |  | Aviation Ins.  |  |  |  | FAA                                  |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |         |  |  |   |                   |  |  |  | 13d. INSIDE CITY LIMITS?   |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |  |         |  |  |   |                   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Maryland Montgomery Chevy Chase  |  |         |  |  |   |                   |  |  |  | 8201 Colston Place   |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |         |  |  | 15. MOTHER'S MAIDEN NAME                                    |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST  |  |         |  |  | FIRST MIDDLE LAST   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| (unknown) Kemper   |  |         |  |  | (unknown)   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  |  | 16b. SOCIAL SECURITY NO.                                    |                   |  |  |  | 17. INFORMANT (son) ADDRESS  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| yes  |  |         |  |  | Korean  |                   |  |  |  | 477-20-5377  |  |                                      |  |          | William R. Kemper- 450 W. 3rd. St. Tustin, Cal.  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |  |   |                   |  |  |  |  |  |                                      |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |  |   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Gunshot wound to head (handgun)  |  |         |  |  |   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |  |   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |         |  |  |   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| (b)  |  |         |  |  |   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |  |   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| (c)  |  |         |  |  |   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |  |   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                   |  |  |  |  |  |                                      |  |          | 20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |                   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)      |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |         |  |  | ? P.M. 5 15 19 80   |                   |  |  |  | self inflicted   |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   |  |  |  | 21f. LOCATION  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |         |  |  | home  |                   |  |  |  | Chevy Chase  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |         |  |  |   |                   |  |  |  | 8201 Colston Place, Silver Spring, Mont., MD.                                      |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |  |   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE   |  |         |  |  |   |                   |  |  |  | TITLE (SPECIFY)  |  |                                      |  |          |  |  |  |  |  | DATE SIGNED                |  |  |  |  |  |  |  |  |  |
| Thomas D. Smith  |  |         |  |  |   |                   |  |  |  | M.D. Deputy Chief  |  |                                      |  |          |  |  |  |  |  | 6/4/80                     |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  |  |   |                   |  |  |  | ADDRESS  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Thomas D. Smith, M.D.  |  |         |  |  |   |                   |  |  |  | 111 Penn St. Balto., MD.   |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  |  | 23b. DATE   |                   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                                      |  |          | 23d. LOCATION  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Cremation  |  |         |  |  | 6-4-80  |                   |  |  |  | Metropolitan Crematory   |  |                                      |  |          | Alexandria Fairfax Va.   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. PREPARETOR'S NAME  |  |         |  |  |   |                   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |                                      |  |          |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |  |  |  |  |  |
| E. Pumphrey, Inc.  |  |         |  |  |   |                   |  |  |  | JUN 1980   |  |                                      |  |          |  |  |  |  |  | [Signature]                |  |  |  |  |  |  |  |  |  |
| 8434 Ga. Ave., S.S. MD.  |  |         |  |  |   |                   |  |  |  |  |  |                                      |  |          |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 1 3 3 1 6  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>EVELYN Naomi KENDRICK</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-8-80</b>  |  |   |  |
| 3 SEX<br><b>Female</b>   |  |  |  | 2b. HOUR<br><b>2 25 PM</b>   |  |   |  |
| 4 RACE<br><b>Caucasian</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>April 3 1910</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b>  |  | 7. # UNDER 1 YEAR # UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |   |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Rockville</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Marshall D. Posey</b>   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ellen Pearl Powell</b>   |  | 17. STREET ADDRESS<br><b>14002 Arctic ave.</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO<br><b>578-36-1840</b>  |  | 17 INFORMANT ADDRESS<br><b>Dale Sheaffer (same as 13e)</b>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>431-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>=</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>=</b> |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 Days</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>5/8 1980</b> to <b>5/8 1980</b> , that (I) (we) saw the deceased alive on <b>5/8 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>H.C. MAGARINI</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>5/10/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H.C. MAGARINI</b>  |  |  |  | 22e. ADDRESS<br><b>50W. Edmonston Dr. Pikesville</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5-12-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Geo. Washington Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Adelphi P.G. Maryland</b>   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>ROBERT A. PUMPHREY FUNERAL HOMES</b>  |  |  |  | ADDRESS<br><b>ROCKVILLE MD.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1980</b>   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>  |  |   |  |

ROBERT A. PURNBERY FUNERAL HOMES 127  
 ROCKVILLE  
 5-12-80 Geo. Washington Coll. Adelphi P.O. Maryland

578-36-1840 Date Sheeter (same as 136)

Harshaji D. Fosy Ellen Pearl Power  
 Maryland Montgomery Rockville X  
 14002 Arctic Ave. Dept. Store

Alabama U.S.A.  
 Caucasian April 3, 1910

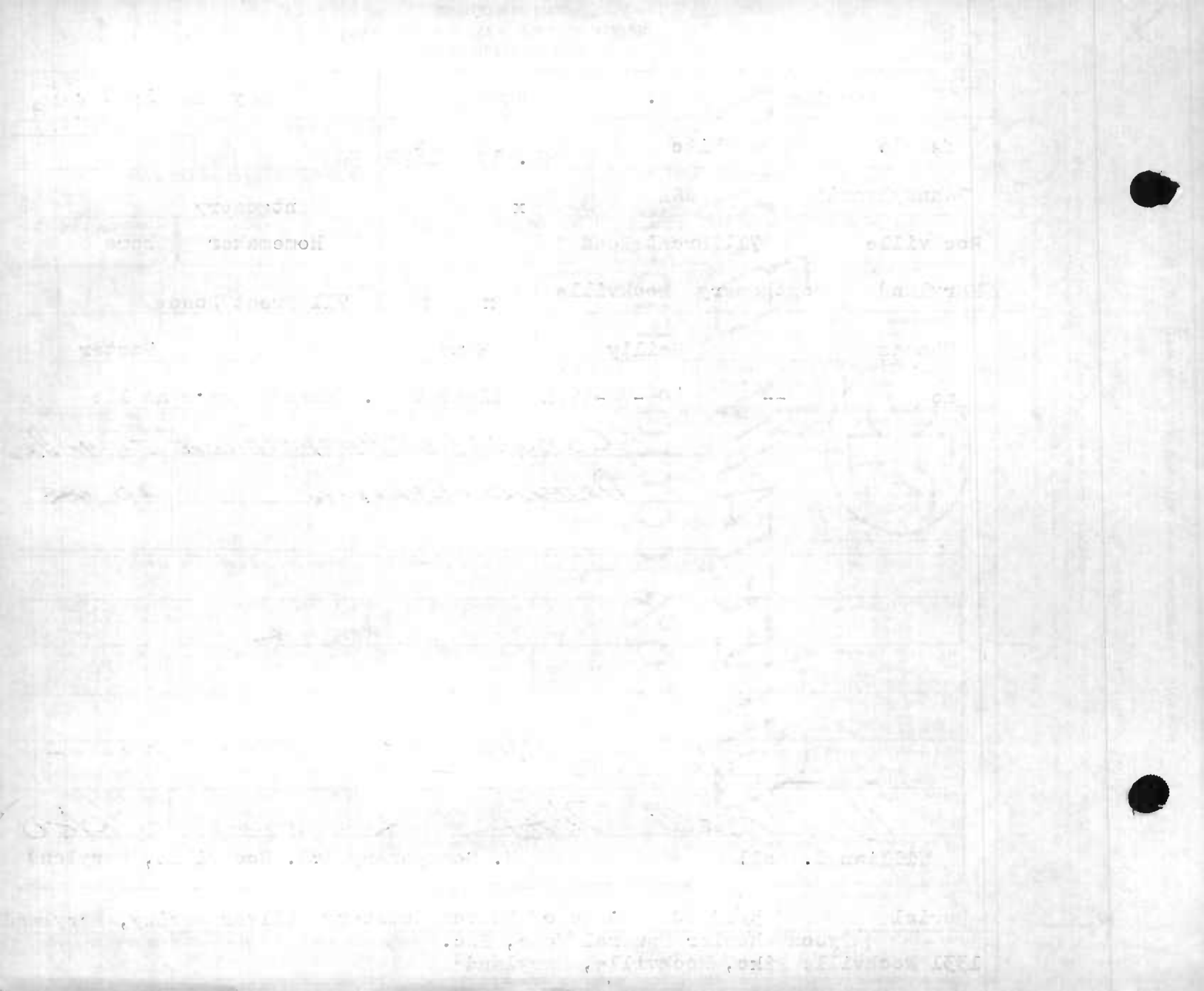
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 1 3 3 1 7  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Pauline R. Kennedy</b>  |  |   |  | 2a. DATE OF DEATH MONTH <b>May</b> DAY <b>10</b> YEAR <b>1980</b>  |  | 2b. HOUR <b>9:15 AM</b>   |  |
| 3. SEX <b>female</b>  |  | 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH MONTH <b>Feb.</b> DAY <b>10</b> YEAR <b>1890</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>711 Brent Road</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS IN LIFE) <b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Rockville</b>  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>711 Brent Road</b>   |  |
| 14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE LAST <b>Reilly</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Emma</b> MIDDLE LAST <b>Porter</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO. <b>409-78-3771</b>                                   |  | 17. INFORMANT ADDRESS <b>Elizabeth P. Kennedy same as 13e</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4409</b> IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24-48 HRS</b><br><b>20 YRS.</b> |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/10</b> , 19 <b>68</b> , to <b>5/10</b> , 19 <b>80</b> , that (I) <del>was</del> lost saw the deceased alive on <b>5/16</b> , 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>W. G. Hall</b> DEGREE <b>M.D.</b>   |  |   |  | 22c. DATE SIGNED <b>5/10/80</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William G. Hall</b>  |  |   |  | 22e. ADDRESS <b>W. Montgomery Ave. Rockville, Maryland</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>5/13/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Maryland</b> STATE  |  |
| 24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home, Inc.</b> NAME ADDRESS <b>1331 Rockville Pike, Rockville, Maryland</b>   |  |   |  | 25. DATE FILED BY REGISTRAR <b>5/13/80</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>ready</b>   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |   |  | 8 0 1 3 3 1 8  |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |  |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Grace D. Kennon   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 28 80   |  |  |  | 2b. HOUR<br>6:50 PM   |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>OCT 4, 1914  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS                                      |  | 7. UNDER 1 YEAR<br>MONTHS DAYS  |  | 7. UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                          |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>10303 DOUGLAS AVENUE                                    |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOHN P. DYER  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>NANOI RICHARDS  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO<br>578-14-5876  |  | 17. INFORMANT<br>JOHN D. KENNON  |  |   |  | 17. ADDRESS<br>SAME AS 13 HUSBAND  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Congestive heart failure<br>2898<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Leukemia, multiple transfusions<br>5 years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) myelofibrosis, myeloid metaplasia<br>9 years |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 21, 1980, to May 28, 1980, that (I) (we) lost saw the deceased alive on May 28, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Deborah B. Goldberg  |  |   |  | DEGREE<br>MD  |  |  |  | 22c. DATE SIGNED<br>5/29/80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Deborah B. Goldberg   |  |   |  | 22e. ADDRESS<br>1106 Spring St, Silver Spring Maryland  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>5/31/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD.      |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS  |  |   |  | 24b. ADDRESS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 29 1980                              |  | 25b. REGISTRAR'S SIGNATURE<br>Ruthy McCready   |  |

STATE OF MARYLAND  
DEPARTMENT OF MATH

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
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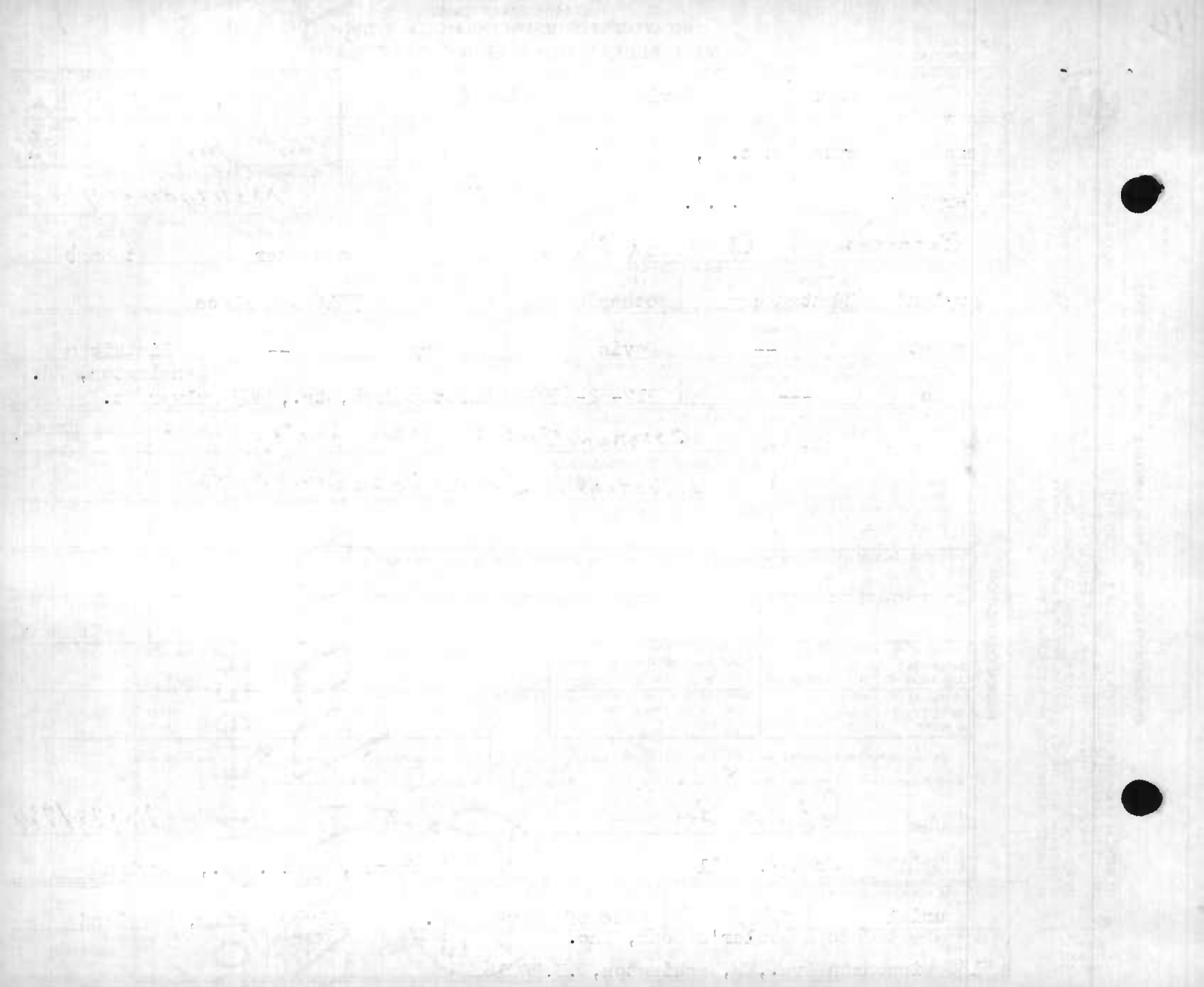
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |         |                  |                                   |   |                     |  |  |   |                                      |  |  |   |  |  |
|---|---------|------------------|-----------------------------------|---|---------------------|--|--|---|--------------------------------------|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |                  | 2a. DATE KNOWN OF DEATH           |   |                     | 2b. DATE KNOWN OF DEATH                      |  |   | 2c. DATE PRONOUNCED DEAD             |  |  | 2d. HOUR  |  |  |
| Edith Davis Kilmain   |         |                  | May 23, 1980                      |   |                     | May 23, 1980                                 |  |   | 8:45                                 |  |  | A M   |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)                 | 7. IF UNDER 24 HRS.   | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |   | 10. CITY OR TOWN OF DEATH            |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION            |  |  |
| Female  | White   | Sept. 5, 1892    | 87 YRS.                           | MONTHS  | DAYS                | Montgomery                                   |  |   | Bethesda                             |  |  | 5516 Oak Place  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?      |   |                     | 8. MARRIED                                   |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  | 10. CITY OR TOWN OF DEATH   |  |  |
| Maryland  |         |                  | U.S.A.                            |   |                     | NEVER MARRIED                                |  |   | Montgomery                           |  |  | Bethesda  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |         |                  | 12b. KIND OF BUSINESS OR INDUSTRY |   |                     | 13a. STATE                                   |  |   | 13b. COUNTY                          |  |  | 13c. CITY OR TOWN   |  |  |
| Homemaker   |         |                  | At Home                           |   |                     | Maryland                                     |  |   | Montgomery                           |  |  | Bethesda  |  |  |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME          |   |                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? |  |   | 16b. SOCIAL SECURITY NO.             |  |  | 17. INFORMANT   |  |  |
| Kenneth Davis   |         |                  | Mary Linthicum                    |   |                     | No   |  |   | 217-52-6394                          |  |  | Dorothy Dosh, Dtr., 9803 Culver St.                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                  |                                   |   |                     |  |  |   |                                      |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |
| PART 1 DEATH WAS CAUSED BY:   |         |                  |                                   |   |                     |  |  |   |                                      |  |  |   |  |  |
| IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.   |         |                  |                                   |   |                     |  |  |   |                                      |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |                                   |   |                     |  |  |   |                                      |  |  |   |  |  |
| (b) Hypertensive Cardiovascular Disease   |         |                  |                                   |   |                     |  |  |   |                                      |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                  |                                   |   |                     |  |  |   |                                      |  |  |   |  |  |
| (c)   |         |                  |                                   |   |                     |  |  |   |                                      |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |                  |                                   |   |                     |  |  |   |                                      |  |  |   |  |  |
| 19a. DATE OF OPERATION  |         |                  |                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                     |  |  |   |                                      |  |  | 20. AUTOPSY?  |  |  |
|   |         |                  |                                   |   |                     |  |  |   |                                      |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS   |         |                  |                                   | 21b. TIME OF INJURY   |                     |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                      |  |  |   |  |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                  |                                   | P.M. 19   |                     |  |  |   |                                      |  |  |   |  |  |
| 21d. INJURY OCCURRED  |         |                  |                                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                     |  |  | 21f. LOCATION   |                                      |  |  |   |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |                  |                                   |   |                     |  |  | CITY OR TOWN COUNTY STATE   |                                      |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |         |                  |                                   |   |                     |  |  |   |                                      |  |  |   |  |  |
| ACTUAL SIGNATURE  |         |                  |                                   | TITLE (SPECIFY)   |                     |  |  | DATE SIGNED   |                                      |  |  |   |  |  |
| John G. Ball  |         |                  |                                   | M.D. Deputy   |                     |  |  | May 23, 1980  |                                      |  |  |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         |                  |                                   | ADDRESS   |                     |  |  |   |                                      |  |  |   |  |  |
| John G. Ball  |         |                  |                                   | Bethesda, Montg. Co., Maryland                              |                     |  |  |   |                                      |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |                  |                                   | 23b. DATE   |                     |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                      |  |  | 23d. LOCATION   |  |  |
| Burial  |         |                  |                                   | 5/27/80   |                     |  |  | Gate of Heaven Cem.   |                                      |  |  | Silver Spring, Maryland   |  |  |
| 24. FUNERAL DIRECTOR  |         |                  |                                   | 25a. DATE RECEIVED BY REGISTRAR                             |                     |  |  | 25b. REGISTRAR'S SIGNATURE  |                                      |  |  |   |  |  |
| Joseph Gawler's Sons, Inc.  |         |                  |                                   | MAY 29 1980   |                     |  |  |   |                                      |  |  |   |  |  |
| NAME  |         |                  |                                   | ADDRESS   |                     |  |  |   |                                      |  |  |   |  |  |
| 5130 Wisconsin Ave., NW   |         |                  |                                   | Washington, D.C. 20016                                      |                     |  |  |   |                                      |  |  |   |  |  |

4503 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |             |                                     |   |  |   |  |  |                         | REG. NO. 13320           |  |   |          |  |  |
|--|--|-------------|-------------------------------------|---|--|---|--|--|-------------------------|--------------------------|--|---|----------|--|--|
| 1. FOR STATE REGISTRAR   |  |             | 1. DECEASED NAME<br>(TYPE OR PRINT) |   |  | FIRST MIDDLE LAST   |  |  | 2a. DATE KNOWN OF DEATH |                          |  | 2b. HOUR  |          |  |  |
|  |  |             | JOAN S. KIM                         |   |  |   |  |  | 5 11 19 80              |                          |  | M   |          |  |  |
| 3. SEX   |  | 4. RACE     |                                     | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | 7. IF UNDER 24 HRS.  |                         | 2c. DATE PRONOUNCED DEAD |  |   | 2d. HOUR |  |  |
| female   |  | oriental    |                                     | Oct. 27, 1947   |  | 32 YRS.   |  | MONTHS DAYS HOURS MIN.   |                         | 5 11 19 80               |  |   | a.m.     |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |             |                                     | 7b. CITIZEN OF WHAT COUNTRY?                                |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         |                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |          |  |  |
| Korea  |  |             |                                     | U. S. A.  |  |   |  |  |                         |                          |  | Montgomery County MD.   |          |  |  |
| 10. CITY OR TOWN OF DEATH  |  |             |                                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                         |                          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |          |  |  |
| Silver Spring  |  |             |                                     | Holy Cross Hospital   |  |   |  | Dental Technician  |                         |                          |  | Dentistry   |          |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |             |                                     |   |  |   |  |  |                         |                          |  |   |          |  |  |
| 13a. STATE   |  | 13b. COUNTY |                                     | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |                         |                          |  |   |          |  |  |
| Maryland   |  | Howard      |                                     | Columbia  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 5462 Harper's Farm Rd., #D4  |                         |                          |  |   |          |  |  |
| 14. FATHER'S NAME  |  |             |                                     |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |                         |                          |  |   |          |  |  |
| FIRST  |  | MIDDLE      |                                     | LAST  |  | FIRST   |  | MIDDLE   |                         | LAST                     |  |   |          |  |  |
| Tae  |  | K,          |                                     | Hahn  |  |   |  |  |                         | Unavailable              |  |   |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |             |                                     | 16b. SOCIAL SECURITY NO.                                    |  |   |  | 17. INFORMANT ADDRESS  |                         |                          |  |   |          |  |  |
| No   |  |             |                                     | 579-74-8911   |  |   |  | Bum S. Kim, Same as 13   |                         |                          |  |   |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |             |                                     |   |  |   |  |  |                         |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |          |  |  |
| PART I DEATH WAS CAUSED BY: Blunt injury to trunk  |  |             |                                     |   |  |   |  |  |                         |                          |  |   |          |  |  |
| IMMEDIATE CAUSE (a)  |  |             |                                     |   |  |   |  |  |                         |                          |  |   |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |             |                                     |   |  |   |  |  |                         |                          |  |   |          |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |             |                                     |   |  |   |  |  |                         |                          |  |   |          |  |  |
| (b)  |  |             |                                     |   |  |   |  |  |                         |                          |  |   |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |             |                                     |   |  |   |  |  |                         |                          |  |   |          |  |  |
| (c)  |  |             |                                     |   |  |   |  |  |                         |                          |  |   |          |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |             |                                     |   |  |   |  |  |                         |                          |  |   |          |  |  |
| 19a. DATE OF OPERATION   |  |             |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |  |                         |                          |  | 20. AUTOPSY?  |          |  |  |
|  |  |             |                                     |   |  |   |  |  |                         |                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |             |                                     | 21b. TIME OF INJURY   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                         |                          |  |   |          |  |  |
|  |  |             |                                     | 8:42 AM MONTH DAY YEAR 5-10-80 P.M.                         |  |   |  | Passenger of auto/fixed object impact  |                         |                          |  |   |          |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |             |                                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |   |  | 21f. LOCATION  |                         |                          |  |   |          |  |  |
|  |  |             |                                     | highway   |  |   |  | Montgomery County Soler Spring, Md.  |                         |                          |  |   |          |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |             |                                     |   |  |   |  |  |                         |                          |  |   |          |  |  |
| ACTUAL SIGNATURE   |  |             |                                     | TITLE (SPECIFY)   |  |   |  | DATE SIGNED  |                         |                          |  |   |          |  |  |
| Virginia L. Dolan  |  |             |                                     | M.D. Assistant  |  |   |  | 5-12-80  |                         |                          |  |   |          |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |             |                                     | ADDRESS   |  |   |  |  |                         |                          |  |   |          |  |  |
| Virginia L. Dolan, M.D.  |  |             |                                     | 111 Penn Street   |  |   |  |  |                         |                          |  |   |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |             |                                     | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |                         | 23d. LOCATION            |  |   |          |  |  |
| Burial   |  |             |                                     | May 15, 1980  |  | Norbeck Memorial Park   |  |  |                         | Olney, Maryland          |  |   |          |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |             |                                     | 25a. DATE REC'D. BY REGISTRAR                               |  |   |  | 25b. REGISTRAR'S SIGNATURE   |                         |                          |  |   |          |  |  |
| ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Rockville, Maryland   |  |             |                                     | MAY 22 1980   |  |   |  |  |                         |                          |  |   |          |  |  |

MEDICAL CERTIFICATION

100-443887-100

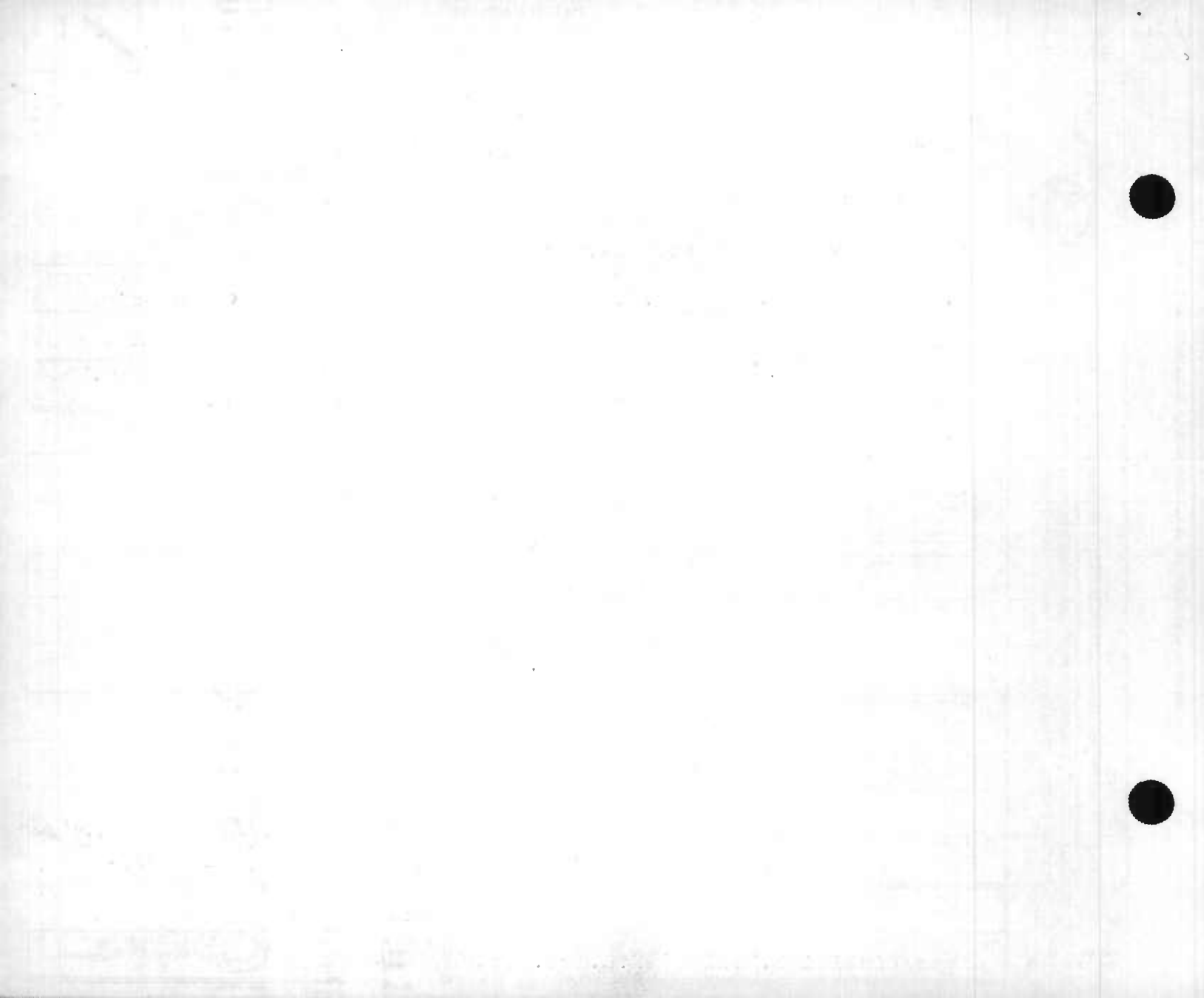


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |                                    |  |                            |  |  |
|---|--|--|---|--|------------------------------------|--|----------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  | 80-13321                           |  |                            |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |   |  | 7a. DATE OF DEATH                  |  |                            |  |  |
| HELEN KOTSIFAKOS  |  |  |   |  | 5 16 80 4:25 AM                    |  |                            |  |  |
| 3 SEX   |  | 4 RACE   |   | 5. DATE OF BIRTH   |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)   |                            | 7b. HOUR   |  |
| Female  |  | White  |   | 1 17 17  |                                    | 63   |                            | 4:25 AM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                            | 10. MONTHS   |  |
| Greece  |  | USA  |   |  |                                    | Montgomery   |                            | MD   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |                            | 13a. STREET ADDRESS  |  |
| Takoma Park   |  | Washington Adventist Hospital  |   | Accountant   |                                    | Safeway  |                            | Stores   |  |
| 13a. STATE  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |                                    | 13d. INSIDE CITY LIMITS?   |                            | 13e. STREET ADDRESS  |  |
| Md.   |  | Mont.  |   | S.S.   |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                            | 11661 Lockwood Drive   |  |
| 14. FATHER'S NAME   |  |  |   |  | 15. MOTHER'S MAIDEN NAME           |  |                            |  |  |
| Peter Koffman   |  |  |   |  | Demetra UNK                        |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |   |  | 16b. SOCIAL SECURITY NO.           |  |                            |  |  |
| None  |  |  |   |  | 577-18-8885                        |  |                            |  |  |
| 17. INFORMANT   |  |  |   |  | 5001 Seminary Road, Alex. Va.      |  |                            |  |  |
|   |  |  |   |  | Louis C. Elefteris (Son)           |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |                                    |  |                            |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |  |                                    |  |                            |  |  |
| IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u>  |  |  |   |  |                                    |  |                            |  |  |
| 2040 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>  |  |  |   |  |                                    |  |                            |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <u>Shock</u>   |  |  |   |  |                                    |  |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Sepsis + Immunosuppression 20 to 40 above 1</u>  |  |  |   |  |                                    |  |                            |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    | 20a. AUTOPSY?  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |   |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                            |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |  |                                    |  |                            |  |  |
|   |  |  | P.M. 19   |  |                                    |  |                            |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION  |                            |  |  |
| WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |   |  |                                    | CITY OR TOWN COUNTY STATE  |                            |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 1976</u> to <u>May 16</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>May 15</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                    |  |                            |  |  |
| 22b. SIGNATURE  |  |  |   |  | DEGREE                             |  |                            | 22c. DATE SIGNED   |  |
| <u>Robert H. Hume</u>   |  |  |   |  |                                    |  |                            | 5/16/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  | 22e. ADDRESS                       |  |                            |  |  |
| ELBA J. MARTINEZ  |  |  |   |  | 8808 HIDDEN HILL LA. - POTOMAC     |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION              |  |  |
| Burial  |  |  | 5/19/80   |  | Cedar Hill Cemetery                |  | CITY OR TOWN COUNTY STATE  |  |  |
|   |  |  |   |  |                                    |  | MD 20894                   |  |  |
| 24. FUNERAL DIRECTOR  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE |  |  |
| Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md.   |  |  |   |  | MAY 19 1980                        |  | <u>Henry McCready</u>      |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |                          |  |   |
|--|--|--|--|---|--|---|--------------------------|--|---|
| 1- FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 13322   |   |                          |  |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE KRAMER LAST KRAMER  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 5 May 14 80 2b. HOUR 7 P.M.   |   |                          |  |   |
| 3 SEX FEMALE   |  | 4 RACE WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR FEB. 18, 1890   |  | 6 AGE (IN YEARS LAST BIRTHDAY) 90   |                          | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA   |  | 7b CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.  |                          |  |   |
| 10 CITY OR TOWN OF DEATH Rockville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE                     |                          | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |                          |  |   |
| 13a STATE MARYLAND   |  | 13b COUNTY MONTGOMERY  |  | 13c CITY OR TOWN SILVER SPRING  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          | 13e STREET ADDRESS 1220 EAST WEST HIGHWAY  |   |
| 14. FATHER'S NAME FIRST ISAAC MIDDLE KANGISSER LAST  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST BEATRICE MIDDLE RABINOWITZ LAST   |   |                          |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO   |  | 16b SOCIAL SECURITY NO. 487-44-6800D   |  | 17 INFORMANT BEATRICE BRODY, 2805 WASHINGTON AVENUE, CHEVY CHASE, MARYLAND  |  |   |                          |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) SEPTICEMIA 0389   |  |  |  |   |  |   |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HOURS |
| DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN   |  |  |  |   |  |   |                          |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) —   |  |  |  |   |  |   |                          |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SEVERE SENILE DEMENTIA  |  |  |  |   |  |   |                          |  |   |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                          | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                          |  |   |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |                          |  |   |
| 22a I certify that (I) (this hospital) attended the deceased from 5/17/1978 to 5/14/1980, that (I) (we) last saw the deceased alive on 5/14/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |                          |  |   |
| 22b SIGNATURE D. D. Patel  |  |  |  |   | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |                          | 22c. DATE SIGNED 5/15/80   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) D. D. PATEL   |  |  |  |   | 22e ADDRESS 6121 MONTROSE RD, ROCKVILLE, MD  |   |                          |  |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b DATE 5/18/1980   |  | 23c NAME OF CEMETERY OR CREMATORY UNITED HEBREW TEMPLE CEMETERY   |  | 23d LOCATION CITY OR TOWN COUNTY STATE UNIVERSITY CITY, MISSOURI                            |                          |  |   |
| 24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.  |  |  |  |   | 25 DATE REC'D BY REGISTRAR MAY 19 1980   |   | 26 REGISTRAR'S SIGNATURE |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |                               |  |
|---|--|--|--|---|--|---|--|--|--|-------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 80-13323   |  |   |  |   |  |  |  |                               |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR                      |  |
| PAULINE   |  |  |  |   |  | KRASNICK  |  | MAY 26 1980  |  | 3:00PM                        |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 7a. IF UNDER 1 YEAR MONTHS DAYS  |  | 7b. IF UNDER 24 HRS HOURS MIN |  |
| FEMALE  |  | WHITE  |  | JULY 9, 1896  |  | 83 YRS.   |  |  |  |                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |                               |  |
| RUSSIA  |  | U.S.A.   |  |   |  | MONTGOMERY  |  |  |  | MD.                           |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |                               |  |
| SILVER SPRING   |  | 1705 EAST WEST HIGHWAY APT. 608  |  | MERCHANT  |  | GROCERIES   |  |  |  |                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS           |  |
| MARYLAND  |  | MONTGOMERY   |  | SILVER SPRING   |  |   |  |  |  | 1705 EAST WEST HIGHWAY        |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |  |   |  |  |  |                               |  |
| RAPHAEL   |  | ALTER  |  | RIFKA   |  | WINNIK  |  |  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO  |  | 17 INFORMANT  |  | ADDRESS   |  |  |  |                               |  |
| NO  |  | 213-40-6436  |  | MRS. EVELYN COHEN,  |  | #8 PALMETTO DRIVE,  |  |  |  |                               |  |
|   |  |  |  |   |  | MARY ESTHER, FLORIDA 32569  |  |  |  |                               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  |  | Cardiac arrest  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |                               |  |
| 4409  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | Arteriosclerosis -  |  |   |  |  |  |                               |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | (c)   |  |  |  |                               |  |
|   |  |  |  |   |  |   |  |  |  |                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |  |  |                               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |                               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-13-1980, to 1980, that (I) (we) last saw the deceased alive on 5-13-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE Robert Kramer   |  | DEGREE  |  | 22c. DATE SIGNED 5/27/80  |  |  |  |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |   |  |  |  |                               |  |
| ROBERT KRAMER, M.D.   |  | 8630 FENTON STREET, SUITE 234, SILVER SPRING   |  |   |  |   |  |  |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |                               |  |
| BURIAL  |  | 5/30/1980  |  | NATIONAL CAPITOL HEBREW CEMETERY IN WASHINGTON  |  | D. C.   |  |  |  |                               |  |
| 24. FUNERAL HOME  |  | 25a. DATE RECEIVED BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |                               |  |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME  |  |  |  |   |  |   |  |  |  |                               |  |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C.  |  |  |  |   |  |   |  |  |  |                               |  |



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR  |  |
| Louise Florence Kristopovich   |  |  |  |  |  |  |  | May 16, 1980  |  | 4:15a M   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 7. IF UNDER 24 HRS. HOURS MIN.  |  |
| Female   |  | White  |  | October 13, 1931   |  | 48 YRS.  |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |  |
| Pennsylvania   |  | U.S.A.   |  |  |  | Montgomery County MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Bethesda   |  | National Institutes of Health  |  |  |  |  |  | Nurse   |  | NIH   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |   |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |   |  |
| Maryland   |  | Montgomery   |  | Silver Spring  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | 9800 McMillan Avenue  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |   |  |   |  |
| John Kristopovich  |  | Agnes Orloški  |  |  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  | 82 South 16th Ave Manville, N.J.  |  |   |  |
| No   |  | 385-38-8645  |  | Joseph Kristopovich  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br><u>1749</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the breast</u><br><u>Metastatic to liver, lungs</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>       |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u><br><u>1-2 years</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>April 20, 1980</u> to <u>May 16, 1980</u> , that <u>X</u> (we) last saw the deceased alive on <u>May 16, 1980</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did (did not) view the body after death. |  |  |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <u>Bruce A. Silver</u>  |  | DEGREE <u>MD</u>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |  |  | 22c. DATE SIGNED <u>5/16/80</u>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BRUCE A. SILVER</u>   |  | 22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20205</u>            |  |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE <u>5/20/80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery Dupont, Pennsylvania</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <u>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</u>  |  | 25a. DATE BY DAY REG. NO. <u>MAY 21 1980</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |  |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



0001 1 2 1 AM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO.   |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH                             |  | 2b. HOUR   |  |
|   |  | FIRST<br>Andrew   |  | MIDDLE<br>J.  |  | LAST<br>KUKUCKA   |  | ESTIMATED<br>May 2 1980                             |  | 355 A  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Cauc.  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 27 1919  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>60 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS                       |  | IF UNDER 24 HRS.<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery  |  | 2d. DATE PRONOUNCED DEAD<br>May 2 1980   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U. S. Army Lt. Col-Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY                   |  | 24 HOUR<br>355A  |  |
| 13a. STATE<br>Maryland  |  | 13b. CITY OR TOWN<br>Montgomery   |  | 13c. CITY OR TOWN<br>Gaithersburg   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>151 Watkins Mill Road Apt. E |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Kukucka  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sophia Gabor   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1940-64  |  | 17. INFORMANT<br>Mrs. Virginia H. Kukucka   |  | ADDRESS<br>See item 13  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intra Cerebral Hemorrhage -</u><br>8160<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Truma Auto-Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>4-19-80</u> |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Bronchopneumonia - Chronic Alcoholism -</u>   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>10 PM 4-19 1980  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><u>Run off road and lost control of car.</u> |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><u>Street</u>  |  | 21f. LOCATION<br>STREET<br><u>Watkins Mill Rd.</u>  |  | CITY OR TOWN<br><u>Gaithersburg</u>   |  | COUNTY<br><u>Mont.</u>                              |  | STATE<br><u>Md.</u>  |  |
| 22a. I certify that I took charge of the remains described above, held on   |  |   |  |   |  |   |  |   |  | Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |  |   |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><u>John G. Ball</u>   |  | TITLE (SPECIFY)<br><u>Deputy</u>  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>2 May 1980                           |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John G. Ball, M. D.   |  | ADDRESS<br>7936 Old Georgetown Rd. Bethesda, Md.  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>5/6/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National  |  |   |  | 23d. LOCATION<br>CITY OR TOWN<br>Arlington          |  |  |  |
|   |  |   |  |   |  |   |  | COUNTY<br>Arlington                                 |  |  |  |
|   |  |   |  |   |  |   |  | STATE<br>Va.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. W. Chambers Co.  |  | ADDRESS<br>Silver Spring, Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 9 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCreedy</u>   |  |   |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
|--|--|---|--|---|--|--|--|------------------------------------|--|-----------------|--|-------|--|------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH                  |  |                 |  | MONTH |  | DAY  |  | YEAR |  | 2b. HOUR |  |
| BENJAMIN   |  |   |  |   |  | KURYK  |  | 5                                  |  |                 |  | 12    |  | 80   |  | 1045 |  | PM       |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR                    |  | IF UNDER 24 HRS |  |       |  |      |  |      |  |          |  |
| MALE   |  | WHITE   |  | JULY - 1892   |  | 87 YRS   |  | MONTHS                             |  | DAYS            |  | HOURS |  | MIN. |  |      |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | MONTGOMERY                         |  | CO.             |  | MD.   |  |      |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| BETHESDA   |  | SUBURBAN HOSPITAL   |  | TAILOR  |  | CLOTHING   |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS                |  |                 |  |       |  |      |  |      |  |          |  |
| MARYLAND   |  | MONT.   |  | POTOMAC   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 9201 ORCHARD BROOK DR.             |  |                 |  |       |  |      |  |      |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| FALKE  |  | REBECCA   |  |   |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | MR. RUBIN KURKOFF  |  | 3302 LAURI RD.                     |  | BALTO., MD      |  | 21209 |  |      |  |      |  |          |  |
| NO   |  | 219-18-2570   |  |   |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u><br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Coronary arteriosclerosis obliterans</u><br>44 hr<br>(c) <u>Coronary arteriosclerosis</u><br>10 yrs |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Generalized Atherosclerosis, Pul. Embolism, Aneurysm &amp; CHF</u>  |  |   |  |   |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/14/80</u> to <u>5/12/80</u> , that (I) (we) lost saw the deceased alive on <u>5/14/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  | 22b. SIGNATURE<br><u>Stephen N. Jones</u>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>5/13/80</u> |  |                 |  |       |  |      |  |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| Stephen N. Jones   |  | 808 Viers Mill Rd., Rockville, Md. 20857  |  |   |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| BURIAL   |  | MAY 14, 1980  |  | PROGRESSIVE BENEFIT & RELIEF ASSOC.   |  | RANDALLSTOWN BALTO. MD   |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |
| SOL LEVINSON & BROS., INC.   |  | MAY 15 1980   |  | REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |                                    |  |                 |  |       |  |      |  |      |  |          |  |

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БЕНДИН КАРК

МАККАНД

БЕНДИН КАРК

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |                                     |   |  |  |
|--|--|--|--|--|--|--|-------------------------------------|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | REG. NO. 8013327   |  |                                     |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>LAURA ELIZABETH LAMOTHE</b>  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>MAY 18 1980</b>                |  |                                     |   |  |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>CAUC</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>DEC 12 1887</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.   |                                     | 7b. HOUR <b>03.8</b> A                        |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CANADA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.   |                                     |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL NAVAL MEDICAL CEN</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY <b>home</b> |  |  |
| 13a. STATE <b>MD</b>   |  |  |  |  | 13b. COUNTY <b>MONTGOMERY</b>                                      |  | 13c. CITY OR TOWN <b>KENSINGTON</b> |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>PHILLIPP OCTAVE KEROVAC</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CELENIRE UNKNOWN</b> |  |                                     |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>  |  | 17. INFORMANT <b>CORINNE LAMOTHE PLANI</b>   |  | ADDRESS <b>11402 ORLEANS WAY KENSINGTON MD WA</b>  |                                     |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>410- MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |  |                                     |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>4-4-4 NONE</b>   |  |  |  |  |  |  |                                     |   |  |  |
| 19a. DATE OF OPERATION <b>NA</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |                                     |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |                                     |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>17 MAY 1980</b> to <b>18 MAY 1980</b> , that (I) (we) last saw the deceased alive on <b>18 MAY 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |                                     |   |  |  |
| 22b. SIGNATURE <b>W. H. Hunt</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED <b>19 MAY 80</b>  |                                     |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. HUNT MD LT, MC. USNR</b>   |  |  |  | 22e. ADDRESS <b>NNMC, BETHESDA, MD 20014</b>   |  |  |                                     |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |  | 23b. DATE <b>5/23/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Manchester New Hampshire</b>  |                                     |   |  |  |
| 24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home, Inc.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 23 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |                                     |   |  |  |
| 24. NAME <b>1331 Rockville Pike Rockville, Maryland</b>  |  |  |  | 25a. ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>  |  |  |                                     |   |  |  |

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W. H. R.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR  |  |         |  |   |  |                   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |                              |  |  |  |                                      |  | REG. NO.  |  |                          |  |          |  |
|--|--|---------|--|---|--|-------------------|--|---|--|--|--|---|--|------------------------------|--|--|--|--------------------------------------|--|---|--|--------------------------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  |   |  |                   |  |   |  | FIRST MIDDLE LAST  |  |   |  |                              |  |  |  |                                      |  | 2b. DATE KNOWN OF DEATH ESTI- MATED                                 |  | 2c. DATE PRONOUNCED DEAD |  | 2d. HOUR |  |
| Elizabeth Margret Lane   |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  | 5/21 1980   |  | 2:20 A.M.                |  |          |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                           |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | MD.   |  |                          |  |          |  |
| Female   |  | Black   |  | May 27, 1906  |  | 73 YRS.           |  |   |  |  |  | Pa.   |  | U.S.A.                       |  |  |  | Montgomery                           |  |   |  |                          |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |                              |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                      |  |   |  |                          |  |          |  |
| Takoma Park  |  |         |  | 7620 Maple Avenue, #523   |  |                   |  |   |  |  |  | Domestic  |  |                              |  | Char   |  |                                      |  |   |  |                          |  |          |  |
| 13a. STATE   |  |         |  | 13b. COUNTY   |  |                   |  | 13c. CITY OR TOWN   |  |  |  | 13d. INSIDE CITY LIMITS?  |  |                              |  | 13e. STREET ADDRESS  |  |                                      |  |   |  |                          |  |          |  |
| D.C.   |  |         |  | N/A   |  |                   |  | Washington, D. C.   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                              |  | 461 H Street, N. W., #620  |  |                                      |  |   |  |                          |  |          |  |
| 14. FATHER'S NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME  |  |                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |                              |  | 17. INFORMANT  |  |                                      |  |   |  |                          |  |          |  |
| Hugh   |  |         |  | Williams  |  |                   |  | Nettie  |  |  |  | No  |  |                              |  | 577-52-1691A   |  |                                      |  | Helen Joyner-Same as # 11 above                                     |  |                          |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |                   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| IMMEDIATE CAUSE (a) <u>Acute leukemia.</u>   |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| (b)  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| (c)  |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDICTIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDICTION GIVEN IN PART 1   |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| None   |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  | 20. AUTOPSY?  |  |                          |  |          |  |
| None   |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                          |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  | 21b. TIME OF INJURY   |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
|  |  |         |  | HOUR A.M. MONTH DAY YEAR  |  |                   |  | None  |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                   |  | 21f. LOCATION   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
|  |  |         |  |   |  |                   |  | CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:   |  |         |  |   |  |                   |  |   |  | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| ACTUAL SIGNATURE   |  |         |  |   |  |                   |  |   |  | TITLE (SPECIFY)  |  |   |  |                              |  |  |  |                                      |  | DATE SIGNED   |  |                          |  |          |  |
| <i>John S. Rogers</i>  |  |         |  |   |  |                   |  |   |  | Deputy   |  |   |  |                              |  |  |  |                                      |  | 5/21/80   |  |                          |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  |   |  |                   |  |   |  | ADDRESS  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| John S. Rogers, M.D.   |  |         |  |   |  |                   |  |   |  | 1919 Seminary Road   |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
|  |  |         |  |   |  |                   |  |   |  | Silver Spring, Montgomery, Md.   |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  | 23d. LOCATION   |  |                              |  | STATE  |  |                                      |  |   |  |                          |  |          |  |
| Burial   |  |         |  | 5-27-80   |  |                   |  | Lincoln Mem. Cem.   |  |  |  | Suttlund, P.G., Md.   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| 24. FUNERAL DIRECTOR   |  |         |  |   |  |                   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  |                              |  |  |  |                                      |  | 25b. REGISTRAR'S SIGNATURE  |  |                          |  |          |  |
| NAME   |  |         |  |   |  |                   |  |   |  |  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
| H.S. WASHINGTON + SONS   |  |         |  |   |  |                   |  |   |  | ADDRESS  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
|  |  |         |  |   |  |                   |  |   |  | 4925 BURROUGHS AVE. N.E.   |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |
|  |  |         |  |   |  |                   |  |   |  | MAY 26 1980  |  |   |  |                              |  |  |  |                                      |  |   |  |                          |  |          |  |

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

Swiss 2-27-50 Lincoln Mem. Com. Switzerland, F.C., Md.

No 527-52-1691A refer Joyner-Same as # 11 above

Harsh Williams Nettie (Unknown)

D.C. W/A

Domestic Chair

Pa. U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |                        |   |   | 8 0 1 3 3 2 9  |  |
|--|------------------------|---|---|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |                        |   |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Catherine E Lautenbach</i>  |                        |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5-7-80</i>  |  | 2b. HOUR<br><i>6:30 PM</i>                                       |
| 3 SEX<br><i>Female</i>   | 4 RACE<br><i>White</i> | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Oct. 2, 1891</i>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>88</i> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Missouri</i>   |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10 CITY OR TOWN OF DEATH<br><i>Wheaton</i>   |                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>University Nursing Home</i> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Ret. Domestic Housekeeping</i>  |                        |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Md.</i> 13b. COUNTY <i>Montg.</i> 13c. CITY OR TOWN <i>Bethesda</i>  |                        |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Christian Bender</i>   |                        |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Maria Daurenheim</i>                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |                        | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><i>495-40-0711</i>  |   | 17 INFORMANT<br>ADDRESS<br><i>Jerome A. Dillon Same as 13</i>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>CORONARY Heart Failure</i><br><i>436-</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>S.V.A. - STROKE - Cerebral</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>81 days</i>                               |                        |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>2 days</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                        |   |   |  |  |
| 19a. DATE OF OPERATION   |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 27, 1980</i> to <i>May 28, 1980</i> that (I) (we) lost<br>saw the deceased alive on <i>May 6, 1980</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                        |   |   |  |  |
| 22b. SIGNATURE<br><i>DR LEO J. DONOVAN</i>   |                        |   |   | 22c. DATE SIGNED<br><i>5-7-80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DR LEO J. DONOVAN</i>  |                        |   |   | 22e. ADDRESS<br><i>218 Wisconsin Ave. Bldg.</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |                        | 23b. DATE<br><i>May 10, 1980</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gate of Heaven</i>  |  |
| 23d. LOCATION<br>CITY OR TOWN<br><i>Silver Spring, Md.</i>   |                        | 23e. COUNTY<br><i>Montgomery</i>  |   | 23f. STATE<br><i>Md.</i>   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>Robert A. Pumphrey</i>   |                        |   |   | 25. DATE REC'D. BY REGISTRAR<br><i>MAY 15 1980</i>   |  |
| HOMES<br><i>Homes, P.A.</i>  |                        |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |
| CITY<br><i>Bethesda, Md.</i>   |                        |   |   |  |  |

Dec. 2, 1941

USA

Assistant

1000 Talbot Ave.

Robert A. Kennedy

Mr.

Paris

Senator

Christian

1000 Talbot Ave. Dec. 2, 1941

x

trial

July 10, 1980 - Case of Heaven

Silver Station, N.J.

Robert A. Kennedy Funeral

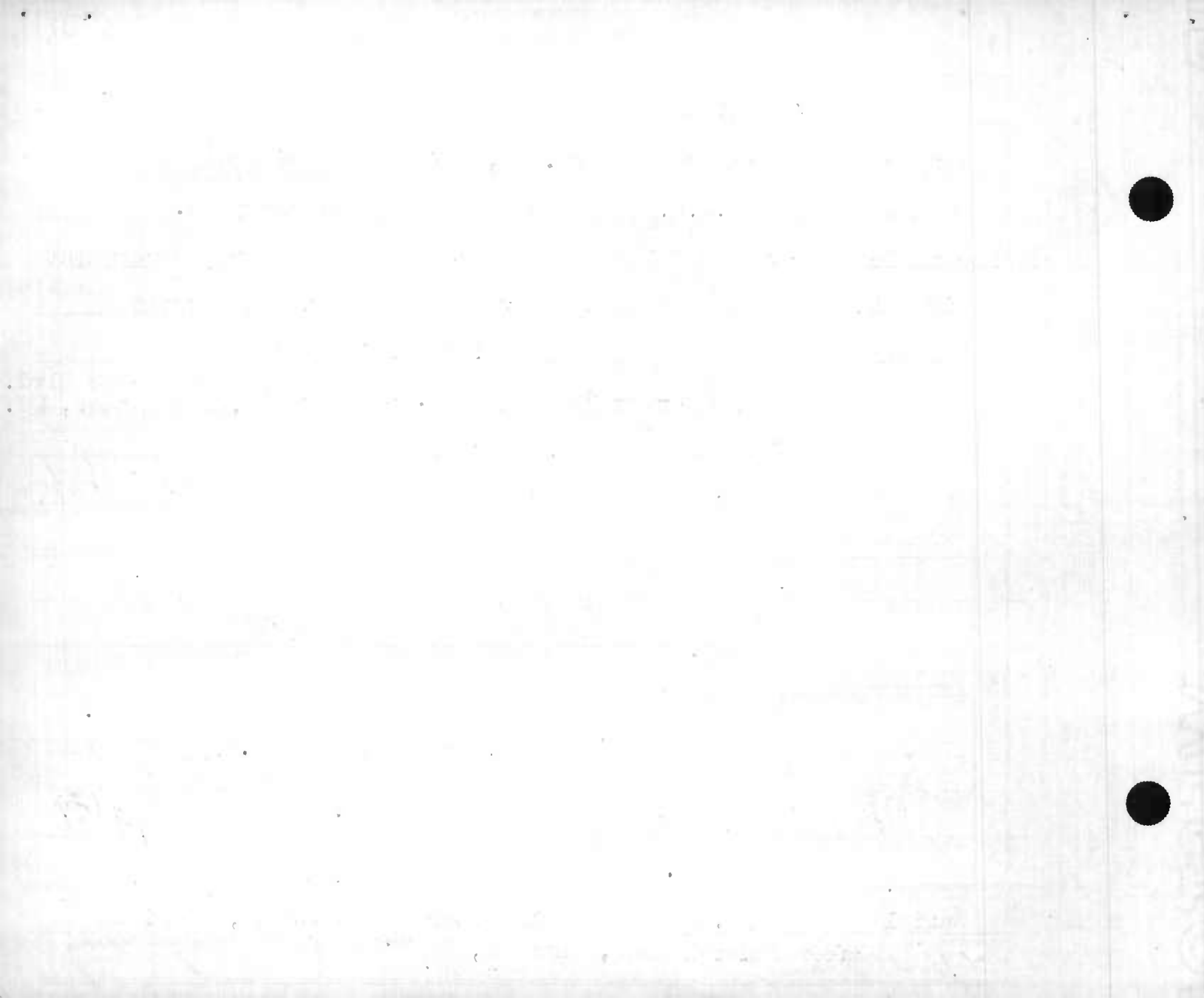
Washington, D.C.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |  |  |  |   |   |  |
|--|--|---|--|---|---|---|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 8 0 1 3 3 3 0   |   |  |  |  |   |   |  |
| CERTIFICATE OF DEATH   |  |   |  |   | REG. NO.  |   |  |  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Eileen Alanna Leach  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>5/4/80                          |   |  |  |  | 2b. HOUR<br>7:50 PM                             |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 18, 1892  |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Indiana   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery Co. MD.                           |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Potomac Valley Nursing Home |  |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor          |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Government |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Virginia   |  |   |  |   | 13b. COUNTY<br>Manassas   |   | 13c. CITY OR TOWN<br>Manassas  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   | 13e. STREET ADDRESS<br>9031 West Street   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Cyrus Hay   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Harriet Pearl Gossard |   |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  |   | 16b. SOCIAL SECURITY NO.<br>226-62-9116                                |   |   | 17. INFORMANT<br>Jeanne L. Espenscheid, 4804 Chevy Chase Blvd. Chevy Chase, Md. |  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cerebral Thrombosis<br>4340<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Cerebral Arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 days<br>4+ years |  |   |  |   |   |   |  |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Urinary Tract Infection, Rheumatoid Arthritis   |  |   |  |   |   |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |  |  |   |   |  |
| 22. I certify that (1) (this hospital) attended the deceased from 4/23/80 to 5/4/80, that (1) (we) last saw the deceased alive on 4/23/80, and that in my opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (not) view the body after death.  |  |   |  |   |   |   |  |  |  |   |   |  |
| 22a. SIGNATURE<br>Michael H. Szalay MD   |  |   |  |   | 22b. DEGREE<br>MD   |   |  | 22c. DATE SIGNED<br>5/4/80                                       |  |   | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   | 22f. ADDRESS  |   |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>5/8/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Stonewall Memory              |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Manassas, Virginia |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>Clifford C. Basing   |  |   |  |   | 25. BY REGISTER<br>9320 West St. Manassas, Va.                      |   |  |  |  |   |   |  |



5600 BP  
DHMH - 16 50M 1/76  
(VR A 15 (4))

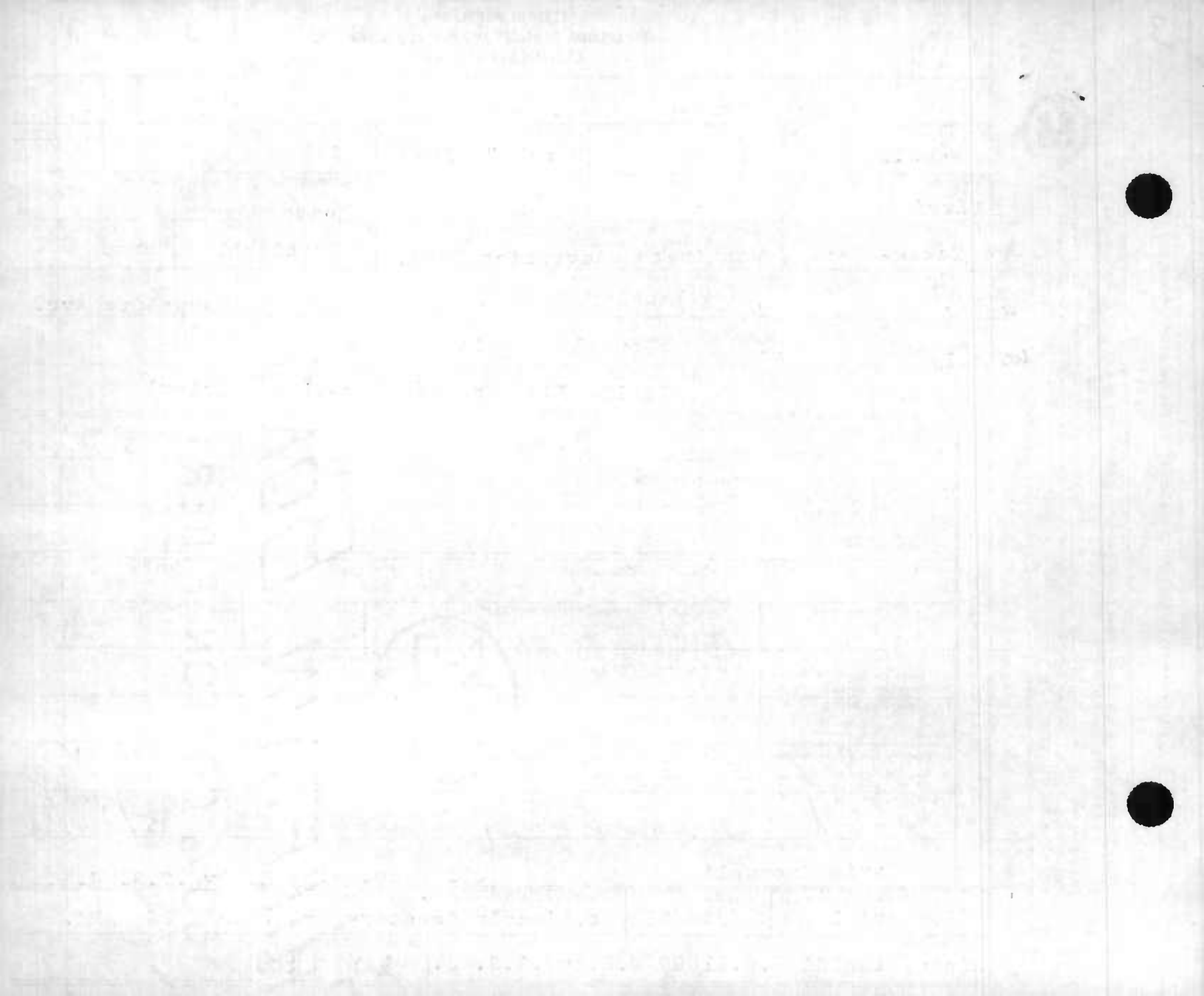
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 70 13331  |   |
|--|--|---|--|--|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PEARLE A. LEATHERS</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>5-25-80</b>  |  | 2b. HOUR P <b>7:30 AM</b>   |
| 3 SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>March 25, 1898</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Practical</b>         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nurse</b>                                    |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>PG</b> 13c. CITY OR TOWN <b>Langley Park</b>  |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Robert H. Yowell</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Ella Weakley</b>                            |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>None</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>579 12 4706A</b>   | 17. INFORMANT Same as above ADDRESS<br><b>Frances Borowiec (Sister)</b>                      |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br><b>436- CVA</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 HOURS.</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>5/17/80</b> to <b>5/26/80</b> , that (1) (we) last saw the deceased alive on <b>5/25/80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) did/did not view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>David Cromwell md</b>   |  |   |  | 22c. DATE SIGNED<br><b>5/26/80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David Cromwell</b>   |  |   |  | 22e. ADDRESS<br><b>831 University E. Blvd. S.S. Md.</b>                              |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>5/28/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>                    |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood PG Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.</b>  |  |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1980</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. McCreedy</b>                                |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

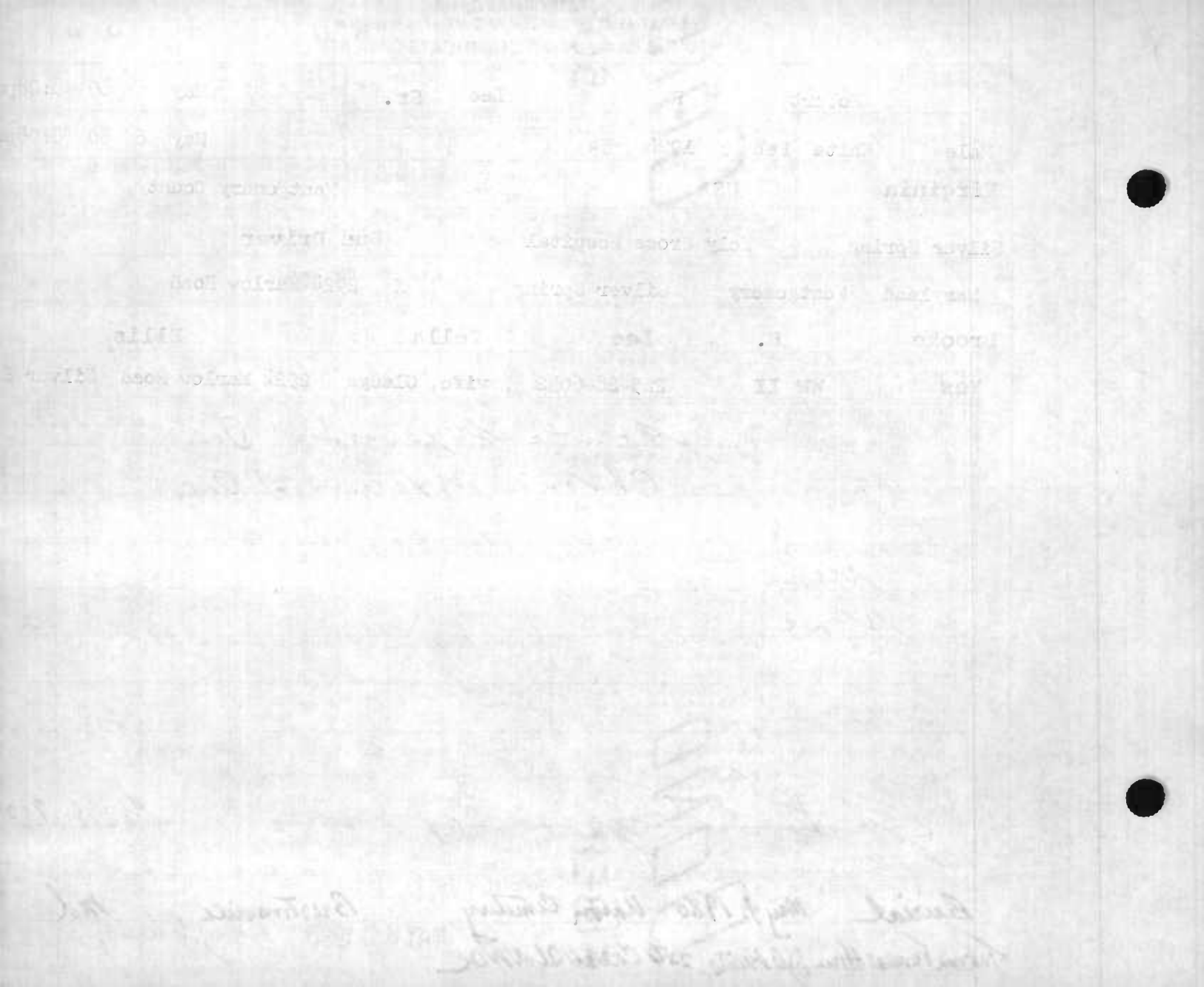
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                  |  |  |  |  |   |  |   |        |         |  |
|--|--|---|------------------|--|--|--|--|---|--|---|--------|---------|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  |   | REG. NO.         |  |  |  |  |   |  |   |        |         |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |   | 2a DATE OF DEATH |  |  | MONTH  |  | DAY   |  | YEAR  |        | 2b HOUR |  |
| CAROL BRIANNE LEE  |  |   | May 16, 1980     |  |  |  |  |   |  |   | 3:05AM |         |  |
| 3 SEX  |  | 4 RACE  |                  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS   |        |         |  |
| Female   |  | White   |                  | April 13, 1956   |  | 24 YRS.  |  | MONTHS  |  | DAYS  |        |         |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |                  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |   |        |         |  |
| Conn.  |  | U.S.A.  |                  |  |  | Montgomery County, MD  |  |   |  |   |        |         |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                  |  |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |  | 12b KIND OF BUSINESS OR INDUSTRY                                  |        |         |  |
| Bethesda   |  | NIH Clinical Center, Bethesda, MD   |                  |  |  |  |  | Teacher-Student   |  | University  |        |         |  |
| 13a STATE  |  |   |                  | 13b COUNTY   |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?   |  | 13e STREET ADDRESS  |        |         |  |
| Indiana  |  |   |                  | Pulaski  |  | Winamac  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | Route 4, Box 407  |        |         |  |
| 14 FATHER'S NAME   |  |   |                  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |   |        |         |  |
| James M. Lee   |  |   |                  | Vivian A. Lukachik   |  |  |  |   |  |   |        |         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |                  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17 INFORMANT   |  | ADDRESS   |  | Same as items #13   |        |         |  |
| No   |  |   |                  | ---  |  | Patients   |  | Mr. & Mrs. James Lee  |  |   |        |         |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Unclassified Sarcoma (metastatic)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br><u>1719</u> |  |   |                  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>7-8 months</u> |        |         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |                  |  |  |  |  |   |  |   |        |         |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  |  |  | 20a AUTOPSY?   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |  |   |        |         |  |
|  |  |   |                  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |        |         |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                  | 21c HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |   |        |         |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |                  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |        |         |  |
| 22a I certify that <u>X</u> (this hospital) attended the deceased from <u>January 29, 1980</u> to <u>May 16, 1980</u> , that <u>X</u> (we) lost<br>saw the deceased alive on <u>May 16, 1980</u> , and that <u>XXX</u> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <u>(X)</u> (we) (did) (did not) view the body after death.                                   |  |   |                  |  |  |  |  |   |  |   |        |         |  |
| 22b SIGNATURE<br><u>Eric H. Weston</u>   |  | DEGREE<br><u>MD</u>   |                  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><u>5/16/80</u>                                   |  |   |        |         |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Eric H. Weston MD</u>   |  | 22e ADDRESS<br>National Institutes of Health<br>Clinical Center, Bethesda, MD 20205                       |                  |  |  |  |  |   |  |   |        |         |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b DATE  |                  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |   |        |         |  |
| Burial   |  | 5/19/80   |                  | McKinley Mem. Gardens-Winamac  |  | Pulaski, Ind.  |  |   |  |   |        |         |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>W. W. Chambers Co., Silver Spring, Md.  |  | ADDRESS   |                  | 25a DATE REC'D. BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE<br><u>Robert H. Brown</u>  |  |   |  |   |        |         |  |
|  |  |   |                  | MAY 21 1980  |  |  |  |   |  |   |        |         |  |

BP



TO-MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 10. PAGES 5 AND 6 SHOULD BE FILED WITHIN 72 HOURS TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |               |  |   |  |   |  |  |  | REG. NO. 13333                       |  |  |  |                            |  |      |  |
|--|--|---------------|--|---|--|---|--|--|--|--------------------------------------|--|--|--|----------------------------|--|------|--|
| 1. FOR STATE REGISTRAR   |  |               |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH              |  |  |  | MONTH DAY YEAR             |  | HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT) Robert R Lee Sr.  |  |               |  |   |  |   |  |  |  | MAY 6 1980                           |  | 8:08pm   |  |                            |  |      |  |
| 3. SEX Male  |  | 4. RACE White |  | 5. DATE OF BIRTH MONTH DAY YEAR Feb 3 1926  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH DAY YEAR May 6 1980                              |  | HOUR 8:08pm                |  |      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County |  |                            |  |      |  |
| 10. CITY OR TOWN OF DEATH Silver Spring  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver   |  |                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |  |                            |  |      |  |
| 13a. STATE Maryland  |  |               |  | 13b. COUNTY Montgomery  |  | 13c. CITY OR TOWN Silver Spring         |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS 2924 Marlow Road |  |  |  |                            |  |      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Brooke E. Lee  |  |               |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zella Ellis  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes   |  |                                      |  | 16b. SOCIAL SECURITY NO. WW II 225-28-6032             |  | 17. INFORMANT wife, Gladys |  |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis.<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) Chronic Myocardial Dis.<br>(c)  |  |               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |                                      |  |  |  |                            |  |      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a) None   |  |               |  |   |  |   |  |  |  |                                      |  |  |  |                            |  |      |  |
| 19a. DATE OF OPERATION None  |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                      |  |  |  |                            |  |      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |                                      |  |  |  |                            |  |      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |                                      |  |  |  |                            |  |      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |               |  |   |  |   |  |  |  |                                      |  |  |  |                            |  |      |  |
| ACTUAL SIGNATURE [Signature]   |  |               |  | TITLE (SPECIFY) M.D. Day  |  |   |  | MEDICAL EXAMINER   |  |                                      |  | DATE SIGNED May 6, 1980                                |  |                            |  |      |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |               |  | ADDRESS   |  |   |  |  |  |                                      |  |  |  |                            |  |      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |               |  | 23b. DATE May 9, 1980   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery  |  |                                      |  | THE LOCATION CITY/TOWN COUNTY STATE Baltimore Md.      |  |                            |  |      |  |
| 24. FUNERAL DIRECTOR NAME [Signature]  |  |               |  | ADDRESS 254 Central St NW DC  |  |   |  | MAY 9 1980   |  |                                      |  |  |  |                            |  |      |  |



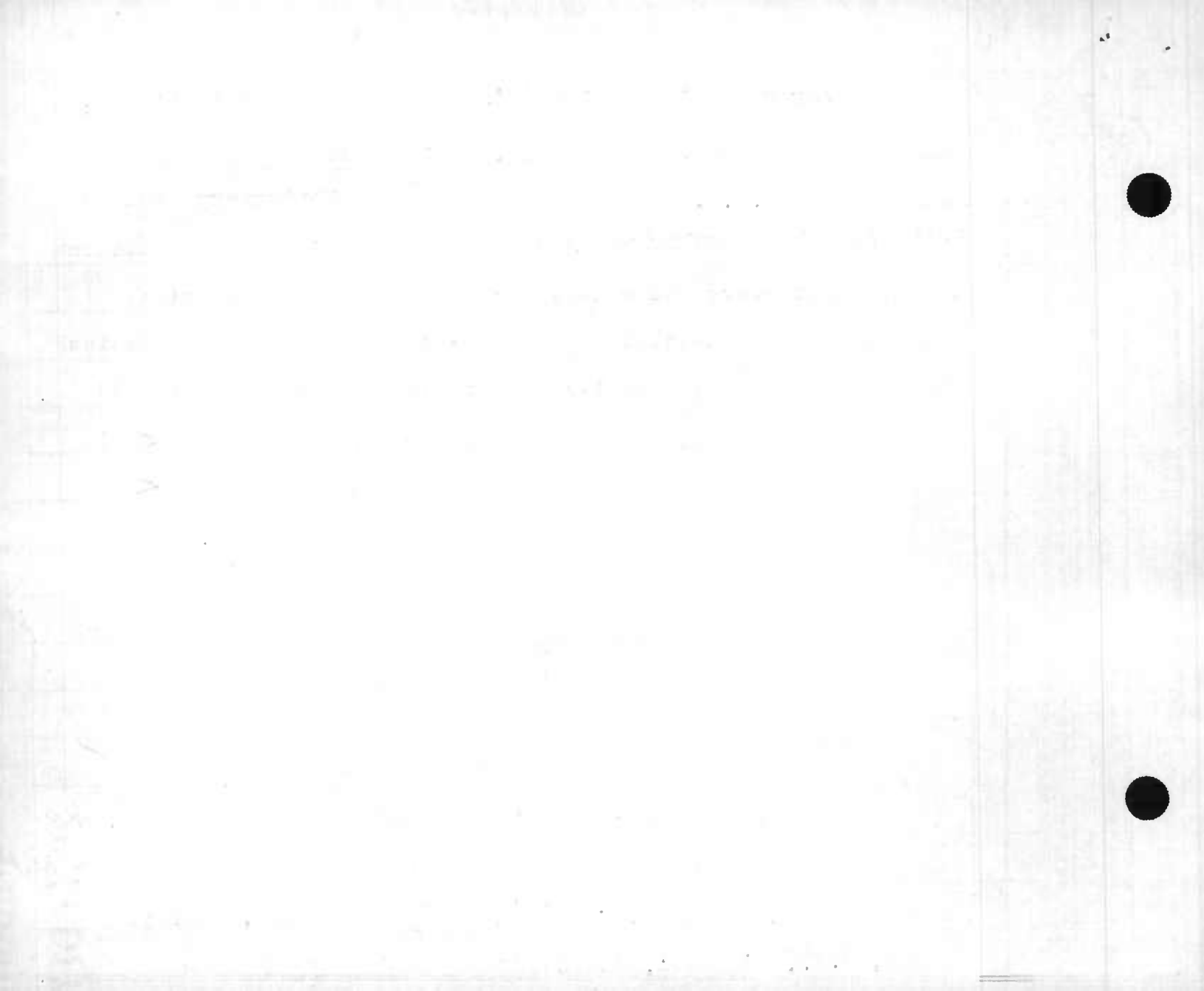
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |                                      |  |               |  |  |
|--|--|--|--|---|--------------------------------------|--|---------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO. 8 0 1 3 3 3 4  |                                      |  |               |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |                                      |  |               | 2b. HOUR P   |  |
| George A Lescisin  |  |  |  | May 5-24-80   |                                      |  |               | 1:30 M   |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |                                      | 6 AGE (IN YEARS LAST BIRTHDAY)   |               | 7. IF UNDER 1 YEAR   |  |
| Male   |  | Caucasian  |  | May 24, 1914  |                                      | 66   |               | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9 BALTIMORE CITY OR COUNTY OF DEATH  |               |  |  |
| Indiana  |  | U.S.A.   |  |   |                                      | Montgomery County MD.  |               |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |               | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Bethesda   |  | Suburban Hospital  |  |   |                                      | Chemist  |               | Research   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13b. INSIDE CITY LIMITS?  |                                      | 13c. STREET ADDRESS  |               |  |  |
| Maryland Montgomery County Chevy Chase   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                      | 4819 Morgan Drive  |               |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |                                      |  |               |  |  |
| Thomas Lescisin  |  |  |  | Mary Yedinak  |                                      |  |               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO   |                                      | 17. INFORMANT ADDRESS  |               |  |  |
| No   |  |  |  | 309 09 1092   |                                      | Mary Lescisin same as item 13  |               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest</u>   |  |  |  |   |                                      |  |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| 410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Myocardial Infarction</u>   |  |  |  |   |                                      |  |               | < 1 hr.  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic coronary Heart Disease</u>   |  |  |  |   |                                      |  |               | Years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |                                      |  |               |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |   |                                      | 20a. AUTOPSY?  |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |   |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |               | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY                              |   |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |               |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR                         |   |                                      |  |               |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY                             |   |                                      | 21f. LOCATION  |               |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |                                      | CITY OR TOWN COUNTY STATE  |               |  |  |
| 22a. I certify that Mr. (this hospital) attended the deceased from <u>1-11-1973</u> to <u>1-24-1980</u> , that he (we) lost saw the deceased alive on <u>2-17-1979</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |  |  |   |                                      |  |               |  |  |
| 22b. SIGNATURE   |  |  |  |   |                                      | DEGREE   |               | 22c. DATE SIGNED   |  |
| Joseph A. Romeo  |  |  |  |   |                                      | M.D.   |               | 5/25/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |                                      | 22e. ADDRESS   |               |  |  |
| Joseph A. Romeo M.D.   |  |  |  |   |                                      | 10401 Old Georgetown Rd. Bethesda, Md.   |               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION |  |  |
| Burial   |  |  | 5/29/80  |   | St. Mary's Eastern Orthodox Cemetery |  | GARY, INDIANA |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   |                                      | DATE REC'D. BY REGISTRAR   |               | 25b. REGISTRAR'S SIGNATURE                                     |  |
| ROBERT A. PUMPHREY<br>HOMES, P.A., BETHESDA, MARYLAND  |  |  |  |   |                                      | JUN 4 1980   |               |  |  |





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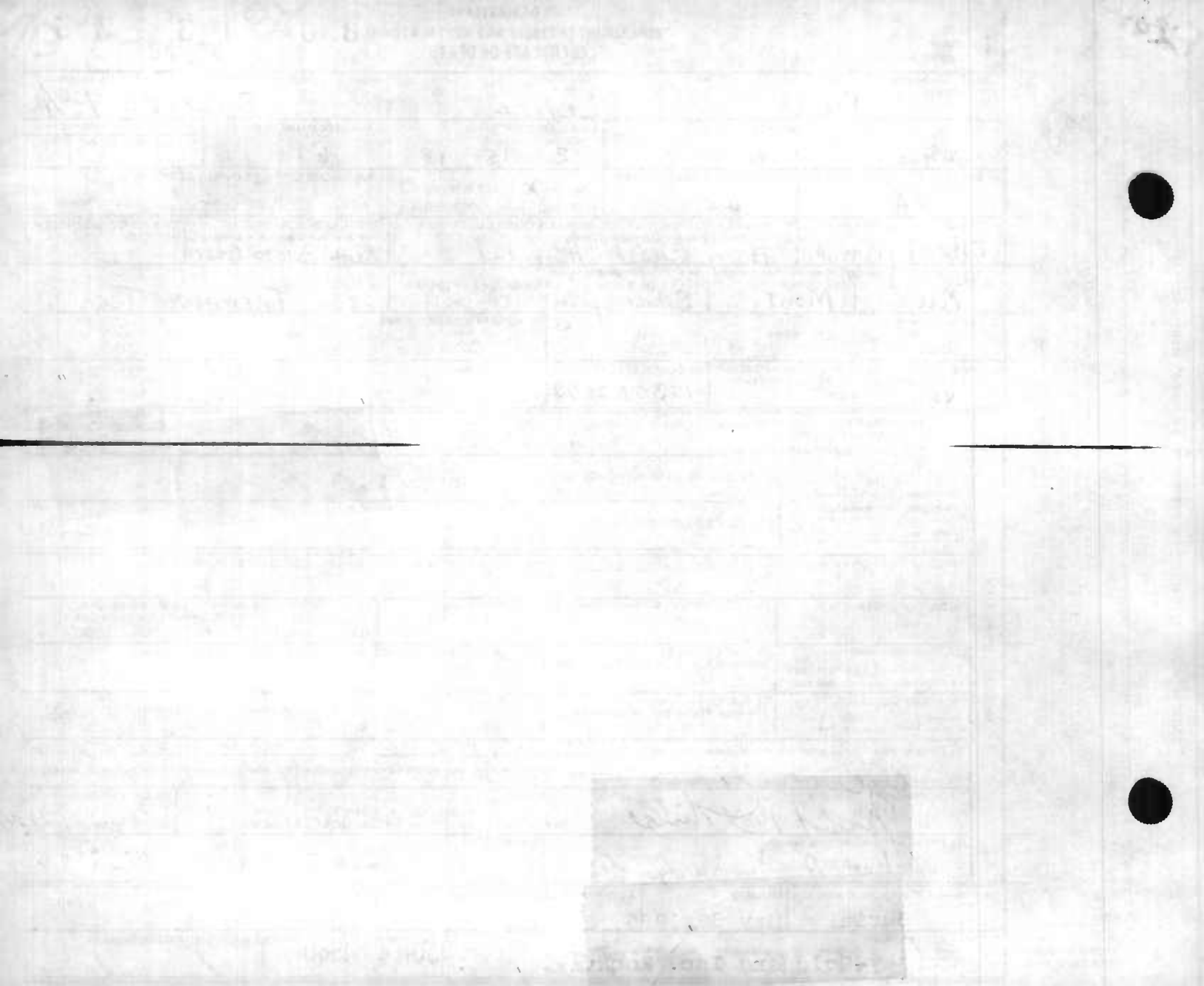
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |   |  |  |  | 8 0 1 3 3 3 5  |  |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1 - STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH   |  |   |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Jules Levine  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5-28-80  |  |   |  | 2b. HOUR<br>7:20 PM  |  |  |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>W   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 15 18   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 8. IF UNDER 24 HRS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD                               |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Silver Spring, Md  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Hony Cross Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Real Estate Broker |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  |  |   |  | 13b. COUNTY<br>Mont.   |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3836 TREMAYNE TERR  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Samuel Levine  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Yetta Loeb   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  |   |  | 16b. SOCIAL SECURITY NO.<br>WW II 173 07 23 70   |  | 17 INFORMANT ADDRESS Gaithersburg, Md.<br>Craig Levine, 9020 Centerway Rd.          |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).<br>410 - Myocardial Infarction  |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b).<br>Coronary Artery Disease   |  |   |  |  |  |   |  |  |  | 3 years  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c).<br>Atherosclerosis   |  |   |  |  |  |   |  |  |  | 3 years  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>Diabetes Mellitus   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                      |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from January 1, 1956, to May 28, 1980, that (I) (we) last saw the deceased alive on May 28, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Michael R. Dudaidsky   |  |   |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  |   |  | 22c. DATE SIGNED<br>May 28, 1980   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael R. Dudaidsky  |  |   |  | 22e. ADDRESS<br>13975 Connecticut Ave Silver Spring  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>May 30, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Judean  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Olney Mont. Md.                           |  |  |  |
| 24 FUNERAL DIRECTOR NAME<br>Danzansky-Goldberg Inc.  |  |   |  | ADDRESS<br>Rockville, Md.  |  | DATE REC'D. BY REGISTRAR<br>JUN 4 1980  |  | 25. REGISTRAR'S SIGNATURE  |  |  |  |



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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |         |                   |   |  |                         |  |   |                         |                  |  |   |  |               |          |  |  |  |  |
|---|--|---------|-------------------|---|--|-------------------------|--|---|-------------------------|------------------|--|---|--|---------------|----------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |         | FIRST MIDDLE LAST |   |  | 2a. DATE KNOWN OF DEATH |  |   | 2b. DATE KNOWN OF DEATH |                  |  | 2c. DATE PRONOUNCED DEAD  |  |               | 2d. HOUR |  |  |  |  |
| Clarence Osceola Lewis  |  |         |                   |   |  |                         |  |   | 5-26-80                 |                  |  | 5:30  |  |               | am       |  |  |  |  |
| 3. SEX  |  | 4. RACE |                   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)       |  | IF UNDER 1 YR.  |                         | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD  |  | 8. MARRIED    |          | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |  |  |
| Male  |  | Negro   |                   | Sep. 30, 1912   |  | 67 YRS.                 |  |   |                         |                  |  | May 26 1980   |  | NEVER MARRIED |          | Montgomery                                   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |                   | 7b. CITIZEN OF WHAT COUNTRY?  |  |                         |  | 8. MARRIED  |                         |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                      |  |               |          | 10. CITY OR TOWN OF DEATH                    |  |  |  |
| Washington, D.C.  |  |         |                   | U.S.A.  |  |                         |  | NEVER MARRIED   |                         |                  |  | Montgomery  |  |               |          | Olney  |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  |  |         |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |                         |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                         |                  |  | 13a. STATE  |  |               |          | 13b. COUNTY                                  |  |  |  |
| Montgomery General Hospital   |  |         |                   | Dentist   |  |                         |  | Dentistry   |                         |                  |  | Maryland  |  |               |          | Montgomery                                   |  |  |  |
| 13c. CITY OR TOWN   |  |         |                   | 13d. INSIDE CITY LIMITS?  |  |                         |  | 13e. STREET ADDRESS   |                         |                  |  | 14. FATHER'S NAME   |  |               |          | 15. MOTHER'S MAIDEN NAME                     |  |  |  |
| Silver Spring   |  |         |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                         |  | 15411 Prince Frederick Way  |                         |                  |  | Clarence O. Lewis   |  |               |          | Rosa Piper                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  |         |                   | 16b. SOCIAL SECURITY NO.  |  |                         |  | 17. INFORMANT   |                         |                  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  |               |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| Yes   |  |         |                   | 1934 - 1972   |  |                         |  | 578-16-1613   |                         |                  |  | Hilda E. Lewis, wife, same as above                                       |  |               |          | PART 1 DEATH WAS CAUSED BY:                  |  |  |  |
|   |  |         |                   |   |  |                         |  |   |                         |                  |  | 4-11- IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.                   |  |               |          |  |  |  |  |
|   |  |         |                   |   |  |                         |  |   |                         |                  |  | (b) Cardiovascular Disease -  |  |               |          |  |  |  |  |
|   |  |         |                   |   |  |                         |  |   |                         |                  |  | (c)   |  |               |          |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |         |                   |   |  |                         |  |   |                         |                  |  |   |  |               |          |  |  |  |  |
| 19a. DATE OF OPERATION  |  |         |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |                         |  |   |                         |                  |  | 20. AUTOPSY?  |  |               |          |  |  |  |  |
|   |  |         |                   |   |  |                         |  |   |                         |                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |               |          |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS   |  |         |                   | 21b. TIME OF INJURY   |  |                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                         |                  |  |   |  |               |          |  |  |  |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |                   | HOUR A.M. MONTH DAY YEAR  |  |                         |  |   |                         |                  |  |   |  |               |          |  |  |  |  |
|   |  |         |                   | P.M. 19   |  |                         |  |   |                         |                  |  |   |  |               |          |  |  |  |  |
| 21d. INJURY OCCURRED  |  |         |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)         |  |                         |  | 21f. LOCATION   |                         |                  |  |   |  |               |          |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>   |  |         |                   |   |  |                         |  | STREET CITY OR TOWN COUNTY STATE  |                         |                  |  |   |  |               |          |  |  |  |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         |                   |   |  |                         |  |   |                         |                  |  |   |  |               |          |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |                   |   |  |                         |  |   |                         |                  |  |   |  |               |          |  |  |  |  |
| ACTUAL SIGNATURE  |  |         |                   | TITLE (SPECIFY)   |  |                         |  | DATE SIGNED   |                         |                  |  |   |  |               |          |  |  |  |  |
| John G. Ball  |  |         |                   | M.D. Deputy   |  |                         |  | May 26, 1980  |                         |                  |  |   |  |               |          |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |                   | ADDRESS   |  |                         |  |   |                         |                  |  |   |  |               |          |  |  |  |  |
| John G. Ball  |  |         |                   | 7728 Groton Rd., Bethesda, Md.                                      |  |                         |  |   |                         |                  |  |   |  |               |          |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         |                   | 23b. DATE   |  |                         |  | 23c. NAME OF CEMETERY OR CREMATORY  |                         |                  |  | 23d. LOCATION   |  |               |          |  |  |  |  |
| Burial  |  |         |                   | May 29, 80  |  |                         |  | Arlington National  |                         |                  |  | Arlington, Arlington, Va.   |  |               |          |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |         |                   | 25a. DATE RECEIVED BY REGISTRAR                                     |  |                         |  | 25b. REGISTRAR'S SIGNATURE  |                         |                  |  |   |  |               |          |  |  |  |  |
| NAME ADDRESS  |  |         |                   | JUN 3 1980  |  |                         |  | McGuire Funeral Ser   |                         |                  |  |   |  |               |          |  |  |  |  |
| 7400 Georgia Ave. NW, Washington, D.C. 20012  |  |         |                   |   |  |                         |  |   |                         |                  |  |   |  |               |          |  |  |  |  |

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows]

107A - 107B

107A - 107B



107A - 107B

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                        |  |   |             |   |                         |  |                           | REG. NO. 13331  |                                 |                                 |
|---|--|------------------------|--|---|-------------|---|-------------------------|--|---------------------------|---|---------------------------------|---------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST JOSEPHINE        |  | MIDDLE M  | LAST LINSON |   | 2a. DATE KNOWN OF DEATH |  | MONTH DAY YEAR<br>5 26 80 |   | 2b. HOUR<br>10 <sup>22</sup> PM |                                 |
| 3. SEX<br>Female  |  | 4. RACE<br>White       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 5 1916   |             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.  |                         | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                           | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5 26 80                               |                                 | 2d. HOUR<br>10 <sup>22</sup> PM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mass.  |  |                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |                           |   |                                 |                                 |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  |                        |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |             |   |                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker           |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |                                 |                                 |
| 13a. STATE<br>Md  |  |                        |  | 13b. CITY OR TOWN<br>Montgomery   |             | 13c. CITY OR TOWN<br>Rockville  |                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                           | 13e. STREET ADDRESS<br>10401 Grosvenor Pl.  |                                 |                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles J. Martell  |  |                        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen F. Contee  |             |   |                         |  |                           |   |                                 |                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-26-6671  |             | 17. INFORMANT<br>Son<br>Maj. Robert G. Linson, 140 Overbrook Rd.  |                         |  |                           | ADDRESS<br>Baltimore, Md.   |                                 |                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency Acute and</u><br>303-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <u>Gastric Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Acute and Chronic Alcoholism</u>                                   |  |                        |  |   |             |   |                         |  |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                 |                                 |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                        |  |   |             |   |                         |  |                           |   |                                 |                                 |
| 19a. DATE OF OPERATION  |  |                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |             |   |                         |  |                           | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 |                                 |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                         |  |                           |   |                                 |                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                         |  |                           |   |                                 |                                 |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                        |  |   |             |   |                         |  |                           |   |                                 |                                 |
| ACTUAL SIGNATURE<br>John G. Ball  |  |                        |  | TITLE (SPECIFY)<br>M.D. DePut   |             |   |                         | MEDICAL EXAMINER   |                           | DATE SIGNED<br>May 26/1980  |                                 |                                 |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John G. Ball, M.D.  |  |                        |  | ADDRESS<br>7936 Old Georgetown Rd., Bethesda, Md.   |             |   |                         |  |                           |   |                                 |                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>5/30/1980 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory  |             |   |                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Maryland.                    |                           |   |                                 |                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph Gawler's Sons Inc.<br>5130 Wisc. Ave., N.W. Wash., D.C.  |  |                        |  |   |             | 25a. DATE READ BY REGISTRAR<br>JUN 2 1980   |                         | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |                           |   |                                 |                                 |

452

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[illegible]

II 102102

12-1-1

•  $\int_{-\infty}^{\infty} \delta(x) dx = 1$

 $\frac{1}{2}$ 

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TD HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TD FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |   |                                   |  |   |   |           |  |
|--|--|---|--|--|--|--|---|-----------------------------------|--|---|---|-----------|--|
| 1. FOR STATE REGISTRAR   |  |   | REG. NO.   |  |  |  |   |                                   |  |   |   |           |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |   | 2a DATE OF DEATH   |  |  | MONTH  |   | DAY                               |  | YEAR  |   | 2b. HOUR  |  |
| Ruth Barbara Long  |  |   | May  |  | 30   |  | 1980  |                                   | 1832   |   | M |           |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                   |   | 7a. MONTHS                        |  | 7b. DAYS  |   | 7c. HOURS |  |
| Female   |  | Caucasian   |  | Dec. 16 1923   |  | 56 YRS.  |   |                                   |  |   |   |           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                              |   |                                   |  |   |   |           |  |
| North Carolina   |  | United States   |  |  |  | Montgomery County MD.  |   |                                   |  |   |   |           |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |   |           |  |
| Bethesda   |  | National Naval Medical Center   |  |  |  | House Wife   |   |                                   |  |   |   |           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS   |                                   |  |   |   |           |  |
| North Carolina   |  |   | Havelock   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 205 Speight St.   |                                   |  |   |   |           |  |
| 14 FATHER'S NAME   |  |   | 15 MOTHER'S MAIDEN NAME  |  |  |  |   |                                   |  |   |   |           |  |
| Clarence Rapehal Caroon  |  |   | Beula (not known) Mason  |  |  |  |   |                                   |  |   |   |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO  |  | 17 INFORMANT ADDRESS   |  |   |                                   |  |   |   |           |  |
| No   |  |   | 414-03-1934  |  | Mr. Wellington B. Long Jr. SAA   |  |   |                                   |  |   |   |           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>HYPOXEMIA</u>   |  |   |  |  |  |  |   |                                   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |   |           |  |
| 2020<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |  |  |  |   |                                   |  |   |   |           |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>MALIGNANT PLEURAL EFFUSIONS</u>  |  |   |  |  |  |  |   |                                   |  |   |   |           |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>STAGE NODULAR POORLY DIFF. LYMPHOMA, IIB</u>   |  |   |  |  |  |  |   |                                   |  |   |   |           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |  |  |   |                                   |  |   |   |           |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |  | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |   |           |  |
|  |  |   |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |   |           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |                                   |  |   |   |           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |                                   |  |   |   |           |  |
|  |  |   |  |  |  |  |   |                                   |  |   |   |           |  |
| 22a. I certify that (this hospital) attended the deceased from <u>MAY 5</u> 19 <u>80</u> to <u>MAY 30</u> 19 <u>80</u> , that (1) <input checked="" type="checkbox"/> lost<br>saw the deceased alive on <u>MAY 29</u> 19 <u>80</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated<br>above, (1) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> not view the body after death. |  |   |  |  |  |  |   |                                   |  |   |   |           |  |
| 22b. SIGNATURE   |  |   |  |  |  | DEGREE   |   | 22c. DATE SIGNED                  |  |   |   |           |  |
| S. A. Chobanian  |  |   |  |  |  |  |   | 31 May 1980                       |  |   |   |           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |  |  | 22e. ADDRESS   |   |                                   |  |   |   |           |  |
| S. A. Chobanian  |  |   |  |  |  | National Nav. Med. Ctr. Bethesda, Md.                            |   |                                   |  |   |   |           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                                   |  |   |   |           |  |
| Burial   |  |   | 6/1/80   |  | National Cemetery  |  | New Bern, Craven N.C.   |                                   |  |   |   |           |  |
| 24 FUNERAL DIRECTOR  |  |   |  |  |  | 25a. REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE        |  |   |   |           |  |
| Chambers Funeral Home Sil. Sprg., Md.  |  |   |  |  |  | JUN 1 1980   |   |                                   |  |   |   |           |  |



Department of the Interior  
Bureau of Land Management  
Washington, D.C.

TO THE SECRETARY OF THE INTERIOR  
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT  
SUBJECT: [Illegible]

Enclosed for the Secretary are two copies of a report  
dated [Illegible] and captioned [Illegible].  
The report was prepared by [Illegible] and [Illegible].  
It contains a detailed description of [Illegible] and  
a list of [Illegible].

Very respectfully,  
[Illegible Signature]  
Director, Bureau of Land Management

Approved: [Illegible Signature]  
Assistant Secretary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 1 3 3 3 9   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>George NELSON Luckett</u>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>MAY 17, 1980</u>  |  | 2b. HOUR<br><u>3:35 PM</u>   |  |
| 3. SEX<br><u>MALE</u>   |  | 4. RACE<br><u>WHITE</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>APRIL 7, 1897</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>83</u> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>WASHINGTON, D.C.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>MONTGOMERY</u> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><u>SILVER SPRING</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>201 BADEN STREET</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>SALESMAN</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>WOODMOOR HARDWARE</u>  |  |
| 13a. STATE<br><u>MARYLAND</u>   |  | 13b. COUNTY<br><u>MONTGOMERY</u>   |  | 13c. CITY OR TOWN<br><u>SILVER SPRING</u>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>SAMUEL A. LUCKETT</u>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>MABEL KELLY</u>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>YES WW I</u>   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><u>577-10-1502</u>  |  | 17. INFORMANT<br>ADDRESS<br><u>MILDRED F. LUCKETT SAME AS 13 WIFE</u>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 yrs.</u> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>80</u> , to <u>5/17</u> , 19 <u>98</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>early May 19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>G. Lennard Gold</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>5/19/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>G. LENNARD GOLD</u>   |  |  |  | 22e. ADDRESS<br><u>8630 FENTON STREET, SILVER SPRING, MD.</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>  |  | 23b. DATE<br><u>5/20/80</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>FT. LINCOLN</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BRENTWOOD PRT GEO ME.</u>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>FRANCIS J. COLLINS</u><br><u>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</u>   |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><u>MAY 19 1980</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Tracy McCready</u>  |  |

700 UNIT, C.D., SILVER SPRING, MD. 20901  
 FRANCIS J. COLLINS  
 5/20/82  
 ELLIOTT LINCOLN  
 BRENTWOOD TRI GEO. WIL.  
 G. LEWIS GOLD  
 6630 JENSON STREET, SILVER SPRING, MD.

VTS 601 1 577-10-1502 WILLIAM F. LUCKETT SALES AS 12 WIFE

SAMUEL A. LUCKETT MABEL KELLY

MARYLAND MONTGOMERY SILVER SPRING X 201 BARD STREET

SILVER SPRING 201 BARD STREET

WASHINGTON, D.C. U.S.A. MONTGOMERY

WHITE APRIL 7, 1997 X

MAY 17, 1997 3:35 PM

## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GRETCHEN S LYNCH</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-25-80</b> |   |  | 2b. HOUR<br><b>3:55P</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 5, 1892</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kansas</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Fernwood House Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. STATE<br><b>W.VA.</b>  |  | 13b. COUNTY<br><b>Harrison</b>  |  | 13c. CITY OR TOWN<br><b>Clarksburg</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>411 Lee Ave.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John W. Spindler</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Camila Zook</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>233-74-4922</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Gretchen Anthony Chevy Chase, Maryland</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metastatic breast carcinoma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 minutes</b><br><b>2 years</b> |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>organic brain disease</b>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>2</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>9</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 25, 1980</b> , to <b>May 25, 1980</b> , that (I) (we) last saw the deceased alive on <b>(Never)</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Mark S. Rosen MD</b>   |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>5/25/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mark S. Rosen, MD</b>   |  |   |  | 22e. ADDRESS<br><b>Silver Spring, Maryland</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-28-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Elk View Masonic Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Clarksburg, West Virginia</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Davis Funeral Home</b> ADDRESS <b>Clarksburg West Virginia</b>  |  |   |  | 25a. RECEIVED BY REGISTRAR<br><b>JUN 2 1980</b>   |  |   |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_

Case No. 2

July 2, 1971

Page 11

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Continued from page 10

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At issue is

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23-24 4012 The 1st of July 1971

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28-29 4012 The 1st of July 1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 0 1 3 3 4 1   |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Raymond Douglas MACCART  |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>May 11 1980  |  |  |  | 2b HOUR<br>5:38P M   |  |  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Caucasian   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 14 1892  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS  |  | 7 UNDER 24 HRS<br>HOURS MIN  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Massachusetts  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                              |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U. S. Navy      |  | 12b KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't   |  |  |  |  |
| 13a STATE<br>Maryland  |  |   |  | 13b COUNTY<br>Montgomery   |  | 13c CITY OR TOWN<br>Chevy Chase  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>4450 South Park Ave. Apt. 801  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elwyn Douglas MacCart   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marion Moore   |  |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |   |  | 16b SOCIAL SECURITY NO<br>WWI<br>094 14 6976   |  | 17 INFORMANT ADDRESS<br>Md. 21146<br>Mr. E. Bonney 854 Cottonwood Dr. Severna Park |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  |   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |  |  |  |  |  |
| 22a I certify that (I (this hospital) attended the deceased from Apr. 27, 1980, to May 11, 1980, that (if (we) lost saw the deceased alive on May 11, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did) (did not) view the body after death.                             |  |   |  |  |  |  |  |  |  |  |  |  |
| 22b SIGNATURE<br>James F. Graves MD  |  |   |  |  |  | DEGREE<br>MD   |  | 22c DATE SIGNED<br>May 13, 1980  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>James F. Graves, M.D.  |  |   |  |  |  | 22e ADDRESS<br>National Naval Medical Center, Bethesda, Md.                        |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |   |  | 23b DATE<br>5-14-80  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory Alexandria Va.         |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Robt. A. Pumphrey Funeral Home, Bethesda, Md.   |  |   |  |  |  | 24b ADDRESS  |  | 25a DATE REC'D. BY REGISTRAR<br>MAY 22 1980  |  | 25b REGISTRAR'S SIGNATURE  |  |  |

Don't

Nov 16

W. J. Jones

5-14-80 Geological Group of the University of California





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 3 4 2  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |  |  |  |  |   |  |  |  |
|--|--|---|---|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Frances A Mack</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>May 20 1980</i>                 |   | 2b. HOUR<br><i>10<sup>34</sup> PM</i>                      |  |  |  |  |   |  |  |  |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>7/31/99</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>81</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.  |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Sp. Md.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>St. Mary's Hospital</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |  |   | 13b. COUNTY<br><i>Montgomery</i>  |   | 13c. CITY OR TOWN<br><i>Silver Spring</i>                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>10,000 Brunswick Ave</i> |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Adam Dumbrowski</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Frances Emelinski</i> |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>214-26-2140</i> |  | 17. INFORMANT<br>ADDRESS<br><i>Springfield, Va</i><br><i>Mr Ronald S Mack 7119 Freshair Dr</i> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <i>Acute Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF (b): <i>Arteriosclerotic Cardiovascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c):<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 hours</i><br><i>Yema</i>  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 20</i> 19 <i>80</i> , to <i>May 20</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>May 20</i> 19 <i>80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not see the body after death, so state.)                             |  |   |   |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Benjamin H. Hurdin, M.D.</i>  |  |   | DEGREE<br><i>M.D.</i>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><i>5-20-80</i>                 |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Benjamin Hurdin, M.D.</i>  |  |   | 22e. ADDRESS<br><i>3720 Fairview Ave, Ken, Md. 20785</i>                  |   |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  |   | 23b. DATE<br><i>5/24/80</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St Stanislaus</i> |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i>   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Leonard J Ruck Inc. Baltimore, Maryland</i>   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 23 1980</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McCreedy</i>  |  |   |  |  |  |

Handwritten text on the right margin, possibly a date or page number.

Main body of the document containing multiple lines of handwritten text, including names and dates, which are mostly illegible due to fading and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 1 3 3 4 3  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Martha B. Majeran</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>05/20/80</b>   |  | 2b. HOUR A. <b>8:30 M</b>  |  |
| 3 SEX <b>Female</b>   |  | 4 RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 6 1916</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. COUNTY <b>Pr. Georges Hyattsville</b> 13d. CITY OR TOWN <b>Essex</b> 13e. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 13f. STREET ADDRESS <b>6500 Riggs Road,</b>  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin Aylor</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Harris</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  |   |  | 16b. SOCIAL SECURITY NO <b>none</b>  |  | 17. INFORMANT ADDRESS <b>324 Hunnel Ave. Musselman Funeral Home-Lavvyne, Pa.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute pneumonia</b><br><b>3352</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Croupy trophic lateral sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>3 yrs</b> |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>4/20</b> <b>1980</b> , to <b>5/20</b> <b>1980</b> , that (I) (we) lost <b>saw the deceased alive on 5/20</b> <b>1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (d-d) did not view the body after death.            |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>Myron L. Lenkin</b>   |  |   |  | DEGREE <b>MD</b>   |  | 22c. DATE SIGNED <b>5/20/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MYRON L. LENKIN</b>  |  |   |  | 22e. ADDRESS <b>2309 SHOREFIELD RD WHEATON MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>5-23-1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dauphin Cty. Penna.</b>   |  |
| 24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 22 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Robert K. Blady</b>  |  |

BP



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1. STATE<br>REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                                     |  | 8 0 1 3 3 4 4  |  |  |  |
|--|--|--|--|---|--|-------------------------------------|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |                                     |  | 2b. HOUR   |  |  |  |
| Kathryn  |  |  |  | 5 16 80   |  |                                     |  | 12 PM  |  |  |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)      |  | 7a. MONTH  |  | 7b. YEAR   |  |
| FEMALE   |  | White  |  | 4-14-1890   |  | 90 YRS                              |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |  |
| AUSTRIA  |  | USA  |  |   |  | Montgomery                          |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| Bethesda   |  | Suburban Hospital  |  | Housewife   |  |                                     |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?            |  | 13e. STREET ADDRESS  |  |  |  |
| D.C.   |  | Washington   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1301 15th Street, N.W.              |  |  |  |  |  |
| 14 FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.            |  | 17. INFORMANT  |  | ADDRESS  |  |
| ANTHONY  |  | MARRON   |  | NO  |  | 577-68-6390                         |  | FREDERICK MALTZ  |  | SAME AS Item 13  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4292  |  |  |  |   |  |                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardio-vascular disease  |  |  |  |   |  |                                     |  | years  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |                                     |  |  |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none   |  |  |  |   |  |                                     |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                     |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |   |  |                                     |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY   |  |                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR P.M. 19  |  |                                     |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |                                     |  | 21f. LOCATION  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |   |  |                                     |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 62 to May 16 19 80, that (I) (we) last saw the deceased alive on 16 May 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.) |  |  |  |   |  |                                     |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |   |  |                                     |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| D. W. E. DeLaughter MD   |  |  |  |   |  |                                     |  | MD   |  | May 16, 80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |  |                                     |  | 22e. ADDRESS   |  |  |  |
| DeWitt E. DeLaughter MD  |  |  |  |   |  |                                     |  | 5500 Friendship Blvd Chevy Chase MD 20014                                      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |  |  |
| Cremation  |  |  |  | 5-20-80   |  | Metropolitan (Arlington)            |  | Alexandria, Virginia   |  |  |  |
| 24 FUNERAL DIRECTOR  |  |  |  |   |  |                                     |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| VANN + WILLIAM FH  |  |  |  |   |  |                                     |  | MAY 22 1980  |  | L. J. McBratney  |  |



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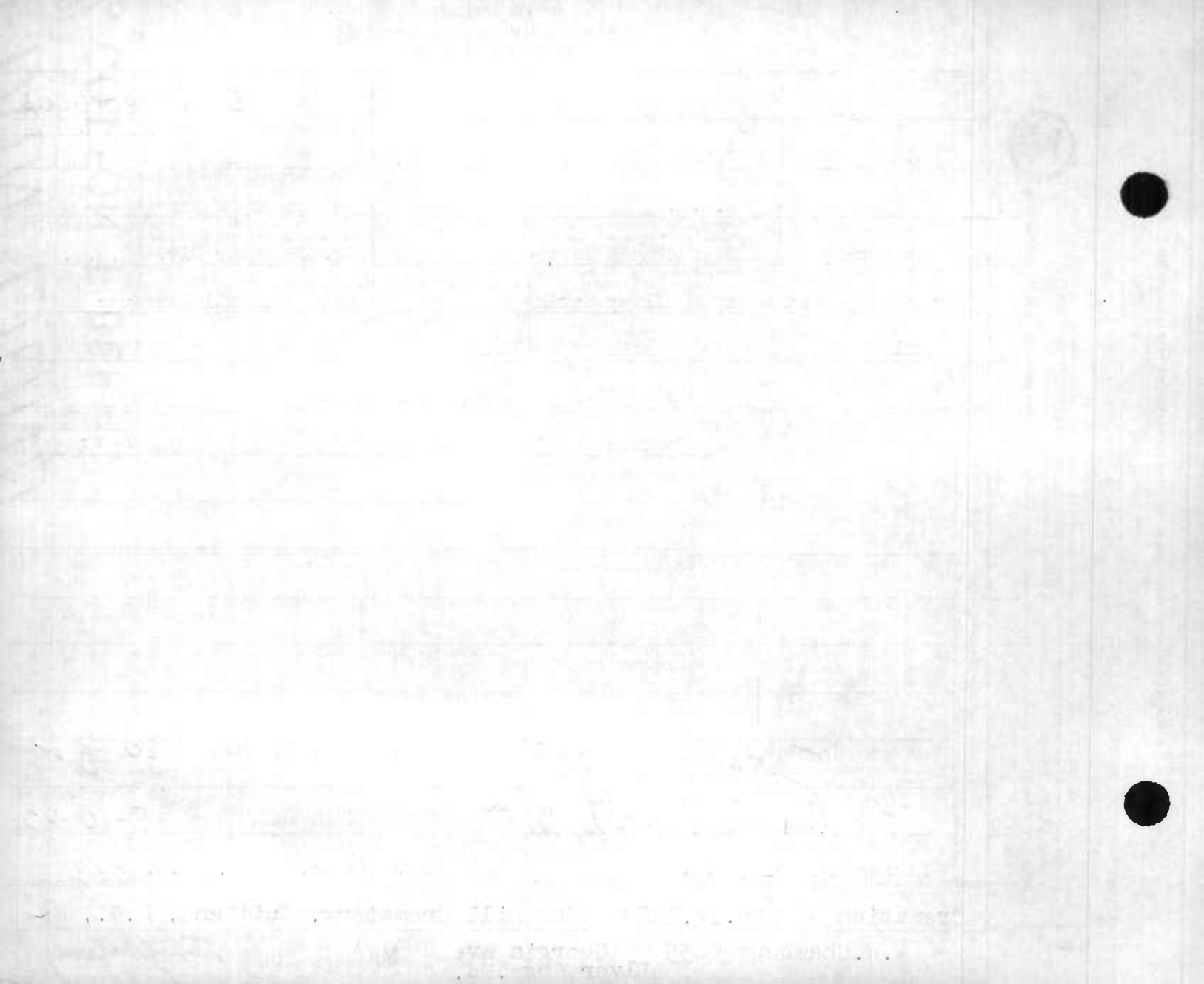
1- FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| Nils Birger Mattsson  |   |  | 5 10 80  |  |  | 600A <sub>M</sub>  |  |  |
| 3 SEX   | 4 RACE  | 5. DATE OF BIRTH   | 6 AGE (IN YEARS LAST BIRTHDAY)   |  |  | IF UNDER 1 YEAR  |  |  |
| Male  | White   | 11 22 17   | 62 YRS   |  |  | MONTHS DAYS HOURS MIN  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                    |  |  |  |  |  |
| Finland   | U.S.A.  |  | Montgomery County, MD.   |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)        |  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |
| Silver Spring   | 2126 Bucknell Terrace   |  | Dir. Computer Div.   |  |  | H.E.W.   |  |  |
| 13a STATE   |   |  | 13b COUNTY   |  |  | 13c CITY OR TOWN   |  |  |
| Maryland  |   |  | Montgomery   |  |  | Silver Spring  |  |  |
| 14 FATHER'S NAME  |   |  | 15 MOTHER'S MAIDEN NAME  |  |  | 13d INSIDE CITY LIMITS?  |  |  |
| Karl  |   |  | Hilja  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |  | 16b SOCIAL SECURITY NO.  |  |  | 17 INFORMANT ADDRESS   |  |  |
| No  |   |  | 390349605  |  |  | Eira Mattsson 2126 Bucknell Terrace  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) Gastric Carcinoma (6-79)  |   |  |  |  |  |  |  | 6-79 → 5-80  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |   |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 7, 1980, to MAY 10, 1980, that (I) (we) lost saw the deceased alive on MAY 7, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  | 22b. SIGNATURE<br>Richard W. Holt, M.D.                                |  |  | 22c. DATE SIGNED<br>5-10-80  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   |  | 22e ADDRESS  |  |  |  |  |  |
| Richard W. Holt, M.D.   |   |  | 3800 Reservoir Rd., Wash., D.C. 20007                                  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |   |  | 23b DATE   |  |  | 23c NAME OF CEMETERY OR CREMATORY  |  |  |
| Cremation   |   |  | May. 12, 1980  |  |  | Cedar Hill Crematory, Suitland, P.G., Md                                       |  |  |
| 24. FUNERAL DIRECTOR NAME   |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| W.W. Chambers 8655  |   |  | MAY 11 1980  |  |  | [Signature]  |  |  |
| ADDRESS   |   |  | 25c. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| Georgia Ave Silver Spgs, Md.  |   |  | [Signature]  |  |  |  |  |  |





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 1 3 3 4 6   |  |  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) <b>LEO MAUSER</b>   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR <b>MAY 17 1980</b>  |  |  |  | 2b HOUR <b>10<sup>40</sup> P. M.</b>  |  |  |  |
| 3 SEX <b>M</b>  |  | 4 RACE <b>WHITE</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>5 03 05</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.  |  | 7 UNDER 1 YEAR MONTHS DAYS  |  | 7 UNDER 24 HRS. HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>YUGOSLAVIA</b>  |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY Co. — MD.</b>  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH <b>WHEATON,</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY NURSING HOME</b> |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BAKER</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a STATE <b>MARYLAND</b>   |  |   |  | 13b COUNTY <b>MONTGOMERY</b>  |  | 13c CITY OR TOWN <b>SILVER SPRING</b>  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS <b>9509 HALE STREET</b>   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>FRANK MAUSER</b>  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAGDALENE</b>  |  |  |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  | 16b SOCIAL SECURITY NO. <b>067-26-0137</b>  |  | 17 INFORMANT ADDRESS <b>MARIA MEJAC SAME AS 13 DAUGHTER</b>  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4409 Sclerotic arteriosclerosis with distention</b>  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one year.</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____  |  |   |  |   |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |  |   |  |  |  |
| 19a DATE OF OPERATION   |  |   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22 I certify that (1) (this hospital) attended the deceased from <b>Oct 31</b> 19 <b>79</b> to <b>May 15</b> 19 <b>80</b> , that (1) (we) lost saw the deceased alive on <b>May 7</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |  |   |  |  |  |   |  |  |  |
| 22b SIGNATURE <b>Michael R. Dobrinski</b>   |  |   |  | DEGREE <b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED <b>May 18 1980</b>  |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael R. Dobrinski MD</b>   |  |   |  | 22e ADDRESS <b>13575 Connecticut Ave Silver Spring, MD</b>  |  |  |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |   |  | 23b DATE <b>5/21/80</b>   |  | 23c NAME OF CEMETERY OR CREMATORY <b>OLD ST. JOHN'S</b>  |  | 23d LOCATION CITY OR TOWN <b>FOREST GLEN</b> COUNTY <b>MONT</b> STATE <b>MD.</b>            |  |  |  |
| 24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>  |  |   |  | 24b ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |  |  |  | 25a DATE REC'D. BY REGISTRAR <b>MAY 19 1980</b>   |  | 25b REGISTRAR'S SIGNATURE <b>Anthony A. Brady</b>  |  |

XX 11.11.11

BAKER

MARYLAND MONTGOMERY SILVER SPRING XX 3509 HALL STREET

FRANK WALTER MAGGALANT

NO 067-24-0137 MARIA PELAC SAME AS 12 DAUGHTER

X

500 UNIV. BLVD., W. SILVER SPRING, MD. 20901  
FRANCIS J. COLLINS  
7/21/80  
010 ST. JOHN'S  
MINIST. CLERK  
MONT. MD.

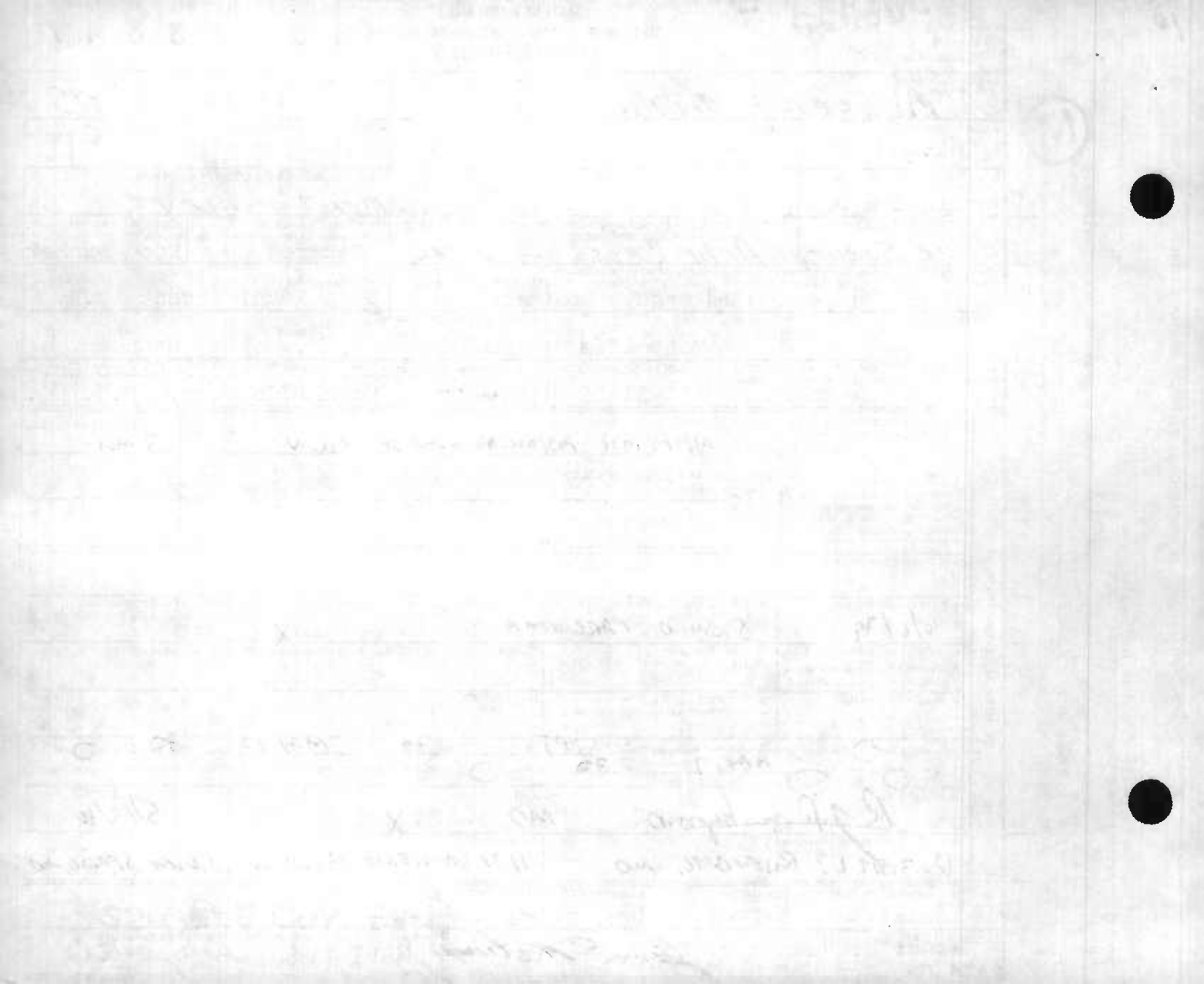
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

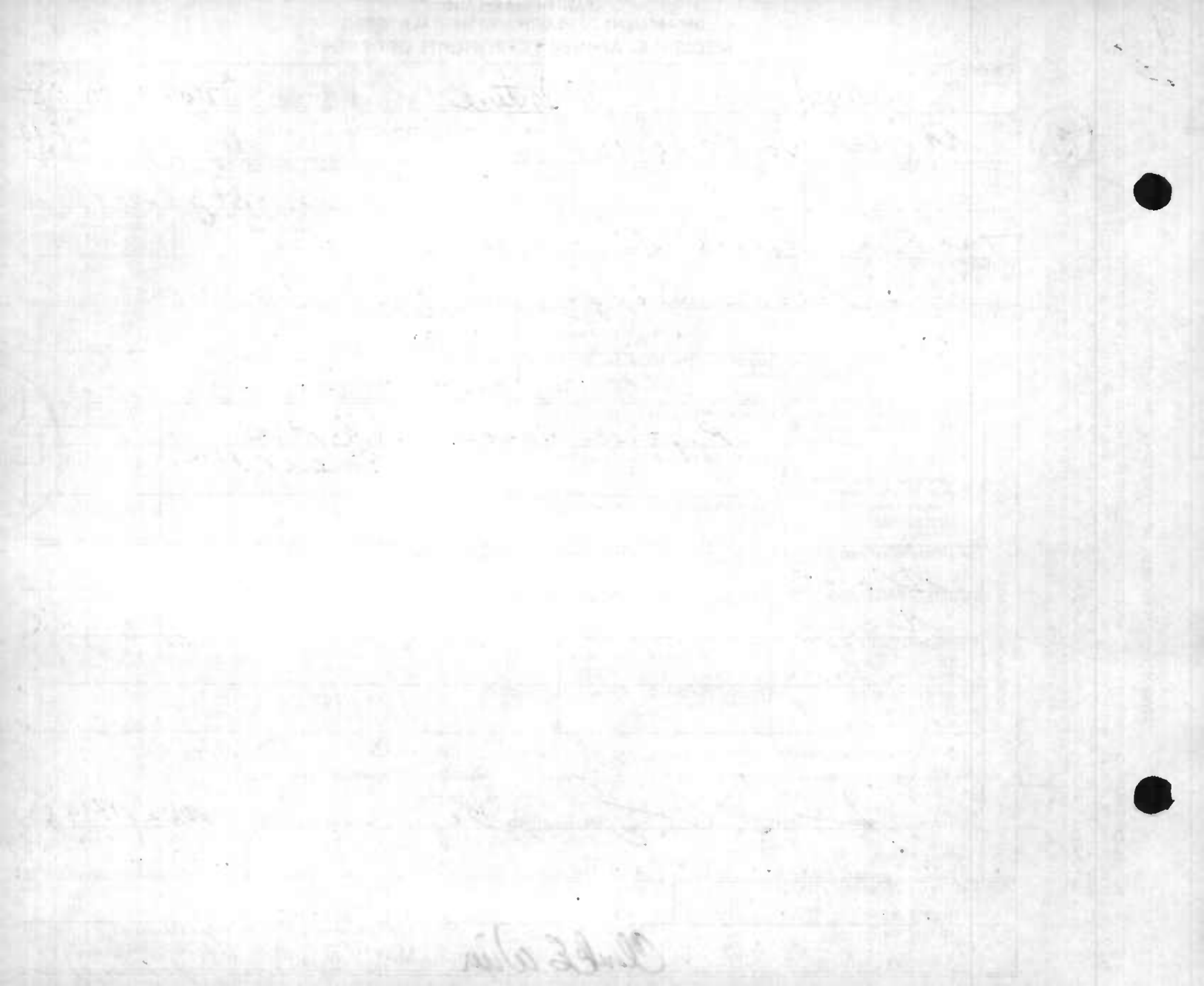
DHMH-16 25M  
(VRA 15, 4) 1/79

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8013347   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>RICHARD F. McAULIFFE</b>  |  |   |  | 5/12/80  |  |   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>12 13 1910   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS<br>69  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, DC  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>SILVER SPRING  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Food broker  |  |
| 13a. STATE<br>--   |  | 13b. COUNTY<br>--   |  | 13c. CITY OR TOWN<br>Wash., DC   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>John J. McAuliffe  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Alice K. Gannon  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>none  |  | 17 INFORMANT (sister) ADDRESS<br>Eleanor P. McAuliffe-Pkwy., S.S. Md.  |  | 9039 Sligo Cr.  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC ADENOCARCINOMA OF COLON</b><br>1533<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>10/6/79  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>SIGMOID CARCINOMA   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>SEPT. 19 79</b> , to <b>MAY 12 1980</b> , that (1) we lost saw the deceased alive on <b>MAY 12 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (2) (we) (did) and not view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>R. J. Rosenber</i>  |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br>5/13/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT L. ROSENBERG, MD.  |  | 22e. ADDRESS<br>1131 UNIVERSITY BLVD. W., SILVER SPRING, MD.  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5-16-1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Washington, DC   |  |
| 24 FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 19 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert J. Rosenber</i>  |  |   |  |
| 8434 Ga. Ave., S.S. Md.  |  |   |  |  |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  | REG. NO. 13348           |  |
|---|--|--|--|--|--|--|--|---|--|--------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE KNOWN OF DEATH ESTIMATED  |  | MONTH DAY YEAR                                    |  | 2b. HOUR                 |  |
|   |  | David McIntyre   |  |  |  | May 13 1980  |  |   |  | 830 AM                   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MINS             |  | 2c. DATE PRONOUNCED DEAD |  |
| M   |  | W  |  | Dec 27 06 73   |  | 73 YRS   |  |   |  | May 13 1980              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  | MD                       |  |
| Maryland  |  | USA  |  |  |  | Montgomery   |  |   |  |                          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |                          |  |
| Tak Park  |  | W 23rd. Advent. Hosp   |  | Retired  |  | Plumbing   |  |   |  |                          |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS                               |  |                          |  |
| MD  |  | Montgomery   |  | Silver Spring  |  |  |  | 629 Sligo Avenue,                                 |  |                          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT (daughter) ADDRESS                  |  |                          |  |
| James McIntyre  |  | Nellie J. Russell  |  | no   |  | 579-10-2502  |  | Beverly Ferramosca- (same as 13e)                 |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |                          |  |
| 4413  |  | Ruptured Abdominal Aortic Aneurysm   |  |  |  |  |  |   |  |                          |  |
|   |  |  |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |                          |  |
|   |  |  |  | (c)  |  |  |  |   |  |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  | None   |  |  |  |  |  |   |  |                          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?   |  |  |  |   |  |                          |  |
| None  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |                          |  |
|   |  | P.M. 19  |  |  |  |  |  |   |  |                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                          |  |
|   |  |  |  |  |  |  |  |   |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)  |  | MEDICAL EXAMINER   |  | DATE <input checked="" type="checkbox"/> 13/19/80 |  |                          |  |
| ACTUAL SIGNATURE  |  | John S. Rogers, DME  |  | ADDRESS  |  | Silver Spring, Maryland  |  |   |  |                          |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE           |  |                          |  |
|   |  | Burial   |  | 5-17-80  |  | St. Marys Cemetery   |  | Washington, DC                                    |  |                          |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |   |  |                          |  |
| Warner E. Pumphrey, Inc.  |  | MAY 19 1980  |  | Pink E. Wain   |  |  |  |   |  |                          |  |
| 8434 Ga. Ave., S.S. Md.   |  |  |  |  |  |  |  |   |  |                          |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 1 3 3 4 9   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST <u>IRENE</u> MIDDLE <u>LAVIN</u> LAST <u>McKAY</u><br><i>Irene Lavin McKay</i>                           |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>5</u> <u>10</u> <u>80</u>  |  | 2b. HOUR / MIN<br><u>1:48</u> <u>P</u>   |  |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>White</u>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>Nov.</u> <u>11</u> <u>1893</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>86</u> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Indiana</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Bethesda</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Suburban Hospital</u>                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><u>Jeweler</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Jewelry</u>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br><u>D.C.</u>                             |  | 13b. COUNTY<br><u>Washington</u>  |  | 13c. CITY OR TOWN<br><u>Washington</u>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><u>Michael</u> <u>Lavin</u>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><u>Eleanor</u> <u>Unknown</u>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>No</u>   |  |  |  |
| 16a. SOCIAL SECURITY NO<br><u>306-18-5792</u>  |  | 17. INFORMANT ADDRESS<br><u>Michael Heid. 12300 Stoney Creek Rd., Potomac, Maryland</u>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute and chronic aspirated pneumonia</u> 5/10/80<br>5070<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | 22. I certify that (I) (this hospital) attended the deceased from <u>April 80</u> , 19____, to <u>5/10/80</u> , 19____, that (I) (we) lost saw the deceased alive on <u>5/10/80</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
| 22b. SIGNATURE <u>[Signature]</u>  |  | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <u>5/10/80</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>OSOTH LEKAGUL MD</u>   |  | 22e. ADDRESS<br><u>7425 Arlington Rd. Bethesda Md</u>   |  | 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  |  |  |
| 23a. DATE<br><u>5/13/1980</u>  |  | 23b. NAME OF CEMETERY OR CREMATORY<br><u>Rock Creek Cem.</u>  |  | 23c. LOCATION CITY OR TOWN COUNTY STATE<br><u>Washington, D.C.</u>  |  | 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u><br>NAME ADDRESS<br><u>5130 Wisc. Ave., N.W. Wash., D.C.</u>  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 16 1980</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |  |  |

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Figure 1

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   | REG. NO. 80 13350  |   |   |  |          |                                |  |
|---|--|---|---|---|--|---|---|--|----------|--------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR   |   |   |  | 2b. HOUR |                                |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>KATE G. McLEAN  |  |   |   |   | MAY 6 1980   |   |   |  | 11:45 PM |                                |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 14 1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |   | 7. IF UNDER 1 YEAR MONTHS DAYS   |          | 8. IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |   |  |          |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home  |          |                                |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery   |   | 13c. CITY OR TOWN<br>Sil. Spr.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>18 Franklin Avenue,   |          |                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Clements  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Eliza Farrell  |   |   |  |          |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>577-12-6796   |   | 17. INFORMANT (son) ADDRESS<br>2703 Nicholson St.,<br>Bernard Wills-W. Hyattsville, Md.   |  |   |   |  |          |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) Coronary artery atherosclerosis<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>instantaneous<br>12 years |  |   |   |   |  |   |   |  |          |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |   |  |   |   |  |          |                                |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |          |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |  |          |                                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |          |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from January 19 68, to May 6 19 80, that (I) (we) lost saw the deceased alive on May 6 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |   |  |          |                                |  |
| 22b. SIGNATURE<br>Blaine H. Eig, M.D.   |  |   |   |   | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>May 7, 1980  |          |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BLAINE H. EIG, M.D.  |  |   |   |   | 22e. ADDRESS<br>9801 Georgia Avenue, Silver Spring, Md 20902   |   |   |  |          |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>May 9, 1980  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Suitland Pr. Georges Md. |  |          |                                |  |
| 24. FUNERAL DIRECTOR<br>Warner E. Pumphrey, Inc.<br>8434 Ga. Ave., S.S. Md.   |  |   |   |   | 25. DATE REC'D BY REGISTRAR<br>MAY 9 1980  |   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |          |                                |  |



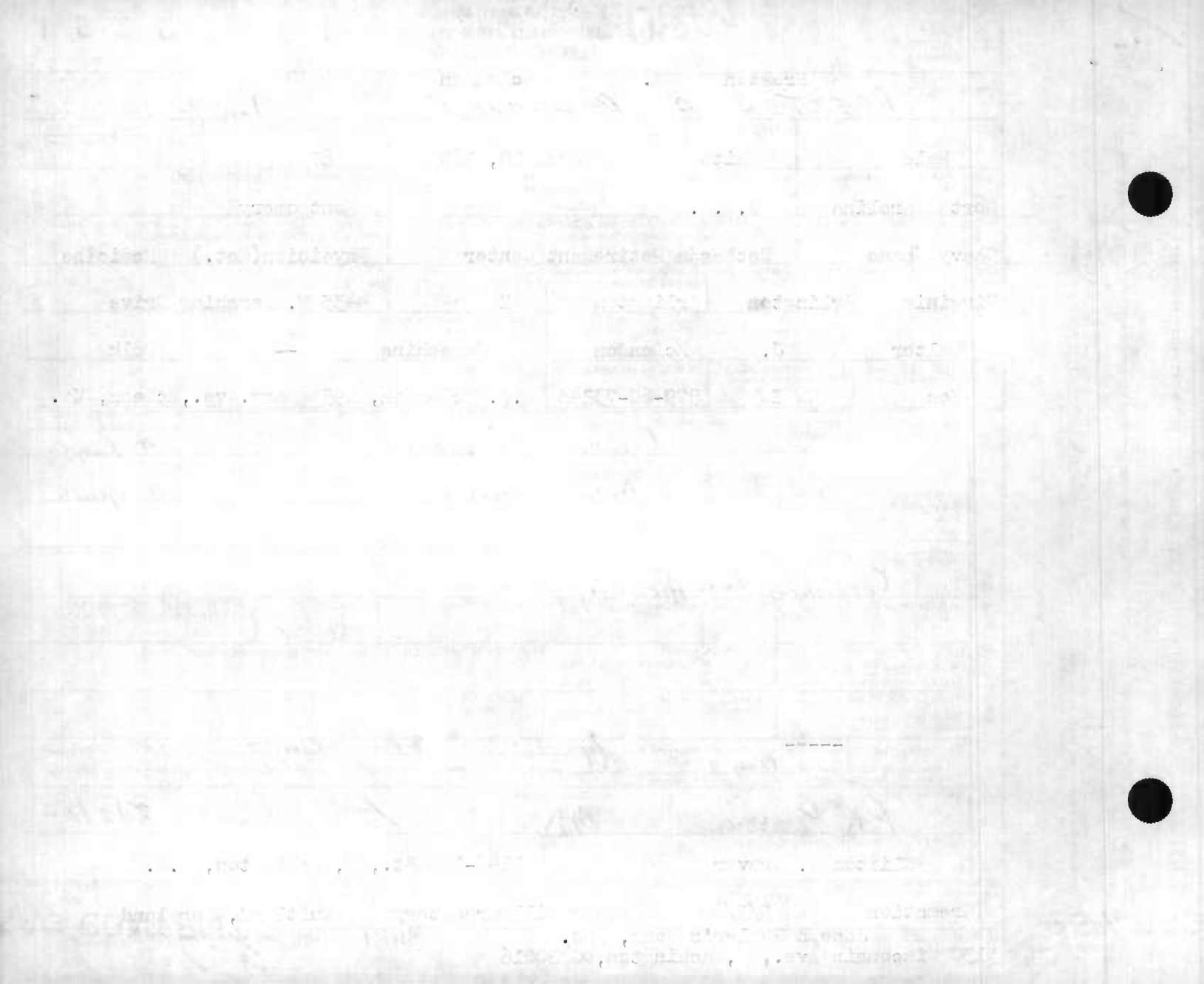
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  | 8013351   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST <u>Preston</u> MIDDLE <u>A.</u> LAST <u>McLendon</u><br><u>PRESTON A McLendon</u>  |  |   |  | 2. DATE OF DEATH MONTH <u>May</u> DAY <u>2</u> YEAR <u>80</u>   |  | 2b. HOUR <u>1:20</u> <sup>A</sup> <sub>M</sub>  |  |   |  |
| 3. SEX<br><u>Male</u>  |  | 4. RACE<br><u>White</u>   |  | 5. DATE OF BIRTH MONTH <u>March</u> DAY <u>20</u> YEAR <u>1893</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>87</u> YRS.                                       |  | 7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN <u></u>                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>North Carolina</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Montgomery</u> MD.                           |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Chevy Chase</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Bethesda Retirement Center</u> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Physician(Ret.)</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Medicine</u>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <u>Virginia</u> 13c. COUNTY <u>Arlington</u> 13d. CITY OR TOWN <u></u>   |  |   |  | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13f. STREET ADDRESS<br><u>4435 N. Pershing Drive</u>                                    |  |   |  |
| 14. FATHER'S NAME FIRST <u>Walter</u> MIDDLE <u>J.</u> LAST <u>McLendon</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Josephine</u> MIDDLE <u></u> LAST <u>Polk</u>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><u>Yes</u>  |  | 16b. SOCIAL SECURITY NO<br><u>579-60-7324B</u>  |  | 17. INFORMANT ADDRESS<br><u>P.A. McLendon, 1958 Mass. Ave., McLean, Va.</u>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br><u>4340</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u><br><u>3 years</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>Coronary Insufficiency</u>  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>April 1</u> , 19 <u>80</u> , to <u>May 2</u> , 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>May 1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.              |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>PR Gruver</u>   |  |   |  | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>5/2/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Clifton R. Gruver</u>  |  |   |  | 22e. ADDRESS<br><u>1145-19th St., NW, Washington, D.C.</u>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Cremation</u>  |  | 23b. DATE<br><u>5/2/80</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Crematory</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Suitland, Maryland</u>                    |  |   |  |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u><br><u>5130 Wisconsin Ave., NW, Washington, DC 20016</u>   |  |   |  | 25. FILED BY <u>MD</u> YEAR <u>1980</u>   |  | 26. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |  |  |  |
|--|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Clayton - McMahon</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-4-80</b>                          |   |  | 2b. HOUR<br><b>8:35A M</b>   |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 13 01</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Labor</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Mont.</b>  |   | 13c. CITY OR TOWN<br><b>Gaithersburg</b>                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>17600 Laytonsville Rd.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John E. McMahon</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eugenia - Thompson</b> |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>    |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Mabel L. Shipe Gaithersburg, Md.</b> |  | 20760   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Ca of Colon</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3mo</b><br><b>2yr.</b> |  |   |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                 |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Daniel L. Anderson</b>  |  |   | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>May 4, 1980</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daniel L. Anderson</b>   |  |   | 22e. ADDRESS<br><b>Olney, Md.</b>  |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>May 6, 1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Oak</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Gaithersburg Mont, Md.</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Francis H. Barber</b>   |  |   | ADDRESS<br><b>Laytonsville, Md. 20760</b>                                  |   |  | DATE REC'D. BY REGISTRAR<br><b>MAY 7 1980</b>  |   | REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |



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Montgomery

Montgomery General Hospital

Army

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | 8 0 1 3 3 5 3                        |  |
|--|--|---|---|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |   | 2b. HOUR                             |  |
| Stacey Lynne MESSERSMITH   |  | May 2 1980  |   | 11:49A <sub>M</sub>                  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS (LAST BIRTHDAY))                                   | 7. BALTIMORE CITY OR COUNTY OF DEATH |  |
| Female   | Caucasian  | Feb. 29 1980  | YRS. 2 2  | Montgomery MD.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                      |  |
| Maryland   | USA  |   | N/A   |                                      |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12b. KIND OF BUSINESS OR INDUSTRY   |   |                                      |  |
| Bethesda   | National Naval Medical Center  |   |   |                                      |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                  |  |
| Virginia   | Fairfax  | Burke   | YES <input type="checkbox"/> NO <input type="checkbox"/>            | 5993 Clerkenwell Court               |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME   | 17. INFORMANT ADDRESS   |   |                                      |  |
| Roger Messersmith  | Stephanie Hunt   | Roger Messersmith See item #13  |   |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   | 17. INFORMANT ADDRESS   |   |                                      |  |
| N/A  | N/A  | See item #13  |   |                                      |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS<br>0389 DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |                                      |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                      |  |
|  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |                                      |  |
| 22a. I certify that (I (this hospital) attended the deceased from Feb. 29 1980 to May 2 1980, that (I (we) last saw the deceased alive on May 2 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.          |  |   |   |                                      |  |
| 22b. SIGNATURE<br>Robert B. North Jr.  | DEGREE   | 22c. DATE SIGNED  |   |                                      |  |
|  |  | May 3, 1980   |   |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e. ADDRESS   |   |   |                                      |  |
| Robert B. North Jr.  | National Naval Medical Center, Bethesda, Md.   |   |   |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                                      |  |
| Burial   | May 5, 1980  | San Lorenzo Cem.  | St. Augustine, Florida  |                                      |  |
| 24. FUNERAL DIRECTOR NAME  | 24b. ADDRESS   |   | 25. NAME REC'D. BY REGISTRAR  |                                      |  |
| Robt. A. Pumphrey Funeral Home, Bethesda, Md.  |  |   | 1980  |                                      |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |  |
|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Alan (NMN) Metcalfe</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 24, 1980</b>                |   | 2b. HOUR<br><b>3:30 PM</b>                       |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 12, 1910</b>                              |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manufacturer</b> |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Heating Elem.</b>  |  |   |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Mont.</b>   |   | 13c. CITY OR TOWN<br><b>Ashton</b>               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Clay Metcalfe</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie - McConnell</b> |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Katherine K. Metcalfe Same as # 13</b>                   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF LEFT LUNG</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>4.30.80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARCINOMA OF LEFT LUNG</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>L. Alberto Nunez</b>  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>  |   | 22c. DATE SIGNED<br><b>5.25.80</b>  |  |  |
| 22d. PHYSICIAN'S EXAMINEE (TYPE OR PRINT)<br><b>L. Alberto Nunez</b>   |  | 22e. ADDRESS<br><b>8218 Wisconsin Ave. Bethesda, Md.</b>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>May 27, 1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Friends Cemetery</b>                           |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sandy Spring Mont. Md.</b>  |  |   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Francis H. Barber Laytonsville, Md. 20760</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 2 1980</b>                        |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |

MEDICAL CERTIFICATION

H 18

1302 BP

10/10/1911

10/10/1911

10/10/1911

CHIEF OF POLICE

DOX CO. N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |                                    |  |   |                                  |   | 8 0 1 3 3 5 5                                |  |
|---|--|--|--|---|------------------------------------|--|---|----------------------------------|---|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   | CERTIFICATE OF DEATH               |  |   |                                  |   |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |   | 2a DATE OF DEATH                   |  |   | 2b HOUR                          |   |  |  |
| John W Miller   |  |  |  |   | May 2, 1980                        |  |   | 7: PM                            |   |  |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH   |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)   |   | IF UNDER 1 YEAR                  |   | IF UNDER 24 HRS                              |  |
| M   |  | W  |  | 12 03 08  |                                    | 71   |   | MONTHS DAYS                      |   | HOURS MIN                                    |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |                                  |   |  |  |
| Wash. D.C.  |  | USA  |  |   |                                    | Montgomery MD.   |   |                                  |   |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                                    | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                   |   | 12b KIND OF BUSINESS OR INDUSTRY |   |  |  |
| Silver Spring   |  | Holy Cross Hospital  |  |   |                                    | Acct. retired  |   | U.S. Govt.,                      |   |  |  |
| 13a STATE   |  | 13b COUNTY   |  | 13c CITY OR TOWN  |                                    | 13d INSIDE CITY LIMITS?  |   | 13e STREET ADDRESS               |   |  |  |
| Maryland  |  | Montgomery   |  | Sil. Spr.   |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 9411 Warren Street,              |   |  |  |
| 14 FATHER'S NAME  |  |  |  | 15 MOTHER'S MAIDEN NAME   |                                    |  |   |                                  |   |  |  |
| William H.C. Miller   |  |  |  | Lillie Wentzell   |                                    |  |   |                                  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b SOCIAL SECURITY NO  |                                    | 17 INFORMANT (wife)  |   | ADDRESS                          |   |  |  |
| no  |  |  |  | none  |                                    | 214-32-7937  |   | Cecilia L. Miller- (same as 13e) |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |                                    |  |   |                                  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BACTERIAL SEPSIS  |  |  |  |   |                                    |  |   |                                  |   | 24-36 HRS                                    |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PNEUMONIA  |  |  |  |   |                                    |  |   |                                  |   | SAME   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |                                    |  |   |                                  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |                                    |  |   |                                  |   |  |  |
| HEMOCHROMATOSIS - CHOLELITHIASIS/CHOLECYSTITIS  |  |  |  |   |                                    |  |   |                                  |   |  |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |                                    |  | 20a AUTOPSY?  |                                  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |  |  |
|   |  |  |  |   |                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY  |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |                                  |   |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR   |   |                                    |  |   |                                  |   |  |  |
|   |  |  | P.M. 19  |   |                                    |  |   |                                  |   |  |  |
| 21d INJURY OCCURRED   |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f LOCATION   |   |                                  |   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |   |                                    | CITY OR TOWN COUNTY STATE  |   |                                  |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 4/7 1980 to 5/2 1980, that (I) (we) lost saw the deceased alive on 5/2 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                                    |  |   |                                  |   |  |  |
| 22b SIGNATURE   |  |  |  |   |                                    | DEGREE   |   |                                  | 22c. DATE SIGNED  |  |  |
| Arnold G. Levy  |  |  |  |   |                                    | MD   |   |                                  | 5-3-80  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |                                    | 22e ADDRESS  |   |                                  |   |  |  |
| ARNOLD G. LEVY, M.D.  |  |  |  |   |                                    | 1106 SPRING ST. SILVER SPRING, MD. 20910                                       |   |                                  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION                    |   |  |  |
| Burial  |  |  | 5-6-1980   |   | Holy Ghost Cemetery                |  |   | Tissue Md.                       |   |  |  |
| 24 FUNERAL DIRECTOR   |  |  |  |   |                                    | 25a. DATE RECEIVED BY REGISTRAR  |   |                                  |   |  |  |
| Warner E. Pumphrey, Inc.  |  |  |  |   |                                    | MAY 7 1980   |   |                                  |   |  |  |
| 8434 Ga. Ave., S.S. Md.   |  |  |  |   |                                    | 25b. REGISTRAR'S SIGNATURE   |   |                                  |   |  |  |
|   |  |  |  |   |                                    | Anthony McCready   |   |                                  |   |  |  |

Chas E. Jones



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |                                  |  |
|--|--|--|--|---|--|---|--|--|--|----------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 8013356   |  |   |  |   |  |  |  |                                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Rose  |  | MIDDLE<br>Gordon  |  | LAST<br>Mintz   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-13-80   |  | 2b. HOUR<br>11:35 A.M.           |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6-23-16   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Canada  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                   |  |  |  |                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Public Schools  |  |                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland   |  | 13c. COUNTY<br>Montgomery  |  | 13d. CITY OR TOWN<br>Silver Spring  |  | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13f. STREET ADDRESS<br>10612 Cavalier Drive  |  |                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Aaron David Gordon   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Stera Ryssen  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>577-38-8356                          |  | 17. INFORMANT<br>ADDRESS<br>Daniel G. Mintz 430 Girard Street, Apt. T-3<br>Gaithersburg, Md. 20760                         |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Inter cerebral hemorrhage</u><br>431-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 hours |  |  |  |   |  |   |  |  |  |                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |   |  |  |  |                                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                                  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>May 13</u> , 19 <u>80</u> , to <u>May 13</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>May 13</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |                                  |  |
| 22b. SIGNATURE<br>Raymond Bradshaw, MD   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>5/13/80   |  |  |  |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Raymond Bradshaw, MD  |  | 22e. ADDRESS<br>345 University Blvd. W<br>Silver Spring, Md. 20901   |  |   |  |   |  |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>5/14/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MOUNT LEBANON CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>HYATTSVILLE, P. G., MD.                           |  |  |  |                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 CARROLL STREET, N.W., WASHINGTON, D.C.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 16 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCreedy   |  |                                  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |                          |  |                   |  |                     | REG. NO.                                     |  |
|---|--|--|--|--|--------------------------|--|-------------------|--|---------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 70                       |  |                   |  |                     | 13357  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH        |  |                   |  |                     | 2b. HOUR                                     |  |
| Karel Miza  |  |  |  |  | May 28, 1980             |  |                   |  |                     | 7:45 AM                                      |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH  |                          | 6 AGE (IN YEARS LAST BIRTHDAY)   |                   | 7. IF UNDER 1 YEAR   |                     | 7. IF UNDER 24 HRS                           |  |
| Male  |  | Caucasian  |  | Jan. 1 1904  |                          | 76   |                   | MONTHS DAYS  |                     | HOURS MIN.                                   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9 BALTIMORE CITY OR COUNTY OF DEATH  |                   |  |                     |  |  |
| Czechoslovakia  |  | U.S.A.   |  |  |                          | Montgomery County MD.  |                   |  |                     |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                          | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)   |                   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                     |  |  |
| Kensington  |  | 10109 Thornwood Court  |  |  |                          | RETIRED ORGANIST   |                   | CHURCH   |                     |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  | 13b. STATE               |  | 13c. CITY OR TOWN |  | 13d. STREET ADDRESS |  |  |
| Maryland  |  |  |  |  | Montgomery               |  | Kensington        |  | 10109 Thornwood Ct. |  |  |
| 14 FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME |  |                   |  |                     |  |  |
| Karel Miza  |  |  |  |  | Maria Fleishans          |  |                   |  |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT   |                          | ADDRESS  |                   |  |                     |  |  |
| No  |  | 499-34-0314  |  | Florence Miza (same as 13e)  |                          |  |                   |  |                     |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |                          |  |                   |  |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>   |  |  |  |  |                          |  |                   |  |                     |  |  |
| 1991 DUE TO, OR AS A CONSEQUENCE OF <u>Metastatic Cancer</u>  |  |  |  |  |                          |  |                   |  |                     |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |  |  |  |                          |  |                   |  |                     |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |                          |  |                   |  |                     |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |                          |  |                   |  |                     |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                          | 20a. AUTOPSY?  |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                     |  |  |
|   |  |  |  |  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                     |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                          |  |                   |  |                     |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |                          |  |                   |  |                     |  |  |
|   |  | P.M. 19  |  |  |                          |  |                   |  |                     |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |                          |  |                   |  |                     |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | CITY OR TOWN COUNTY STATE  |                          |  |                   |  |                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 12</u> , 19 <u>80</u> , to <u>May 22</u> , 19 <u>80</u> , that (I) (we) lost  |  |  |  |  |                          |  |                   |  |                     |  |  |
| saw the deceased alive on <u>May 22</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                          |  |                   |  |                     |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |  |                          | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                   | 22c. DATE SIGNED   |                     |  |  |
| <u>Christopher Unger</u>  |  | M.D.   |  |  |                          |  |                   | 5/28/80  |                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |                          |  |                   |  |                     |  |  |
| Christopher Unger   |  | 8218 Wisconsin Avenue<br>Bethesda, Maryland 20014  |  |  |                          |  |                   |  |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION  |                   | 23e. STATE   |                     |  |  |
| Cremation   |  | 5-29-80  |  | Metropolitan Crematory   |                          | Alexandria   |                   | Fairfax Virginia   |                     |  |  |
| 24 FUNERAL DIRECTOR   |  | ADDRESS  |  |  |                          | 25a. DATE REC'D. BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE                                     |                     |  |  |
| ROBERT A. PUMPHREY FUNERAL HOMES P/A  |  | ROCKVILLE MD.  |  |  |                          | JUN 3 1980   |                   |  |                     |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  | REG. NO. 8013358  |   |  |   |  |  |
|---|--|--|--|--|--|--|--|---|--|---|---|--|---|--|--|
| FOR<br>1- STATE REGISTRAR   |  |  |  |  |  |  |  |   |  |   |   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARY MIDDLE ELLA LAST MOFFETT   |  |  |  |  | 2a. DATE OF DEATH MONTH MAY DAY 10 YEAR 1980   |  |  |   |  | 2b. HOUR 21.5 M   |   |  |   |  |  |
| 3. SEX FEMALE   |  |  | 4. RACE CAUCA.   |  | 5. DATE OF BIRTH MONTH JAN DAY 11 YEAR 1883  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS 93   |  |   | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.      |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND  |  |  | 7b. CITIZEN OF WHAT COUNTRY? US  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD                        |  |   |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH BETHESDA  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE               |  |   | 12b. KIND OF BUSINESS OR INDUSTRY           |  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE VIRGINIA 13c. COUNTY FAIRFAX 13d. CITY OR TOWN MCLEAN   |  |  |  |  |  |  |  |   |  | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |   |  | 13f. STREET ADDRESS 6251 OLD DOMINION DR. |  |  |
| 14. FATHER'S NAME FIRST HARRY MIDDLE UNK LAST MOFFETT   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST UNK MIDDLE UNK LAST MOFFETT   |  |  |   |  |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES   |  |  | 16b. SOCIAL SECURITY NO. 7 DEC 1912  |  | 17. INFORMANT MR. KENT NICKERSON BX4054 R3 STAFFORD VA.  |  |  |   |  |   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC FAILURE  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |   |  |  |
| 5609 } DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE  |  |  |  |  |  |  |  |   |  |   |   |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |   |  |   |   |  |   |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE  |  |  |  |  |  |  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION 30 APR 1980  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SMALL BOWEL OBSTRUCTION   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 27 APR 1980 to 10 MAY 1980, that (I) (we) last saw the deceased alive on 10 MAY 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE J. P. MURPHY, LT, MC, USN  |  |  |  |  | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  |  |   |  | 22c. DATE SIGNED 11 MAY 1980  |   |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. P. MURPHY, LT, MC, USN   |  |  |  |  | 22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD   |  |  |   |  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |  |  | 23b. DATE May 11, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Cremat.  |  |  | 23d. LOCATION CITY OR TOWN Alexandria, Virginia                                   |  |   | COUNTY STATE                                |  |   |  |  |
| 24. FUNERAL DIRECTOR NAME Ives Funeral Home, 2847 Wilson Blvd.,   |  |  |  |  | ADDRESS Arlington, Va.   |  |  | 25a. DATE MAY 15 1980   |  |   | 25b. BY REGISTRAR AND REGISTRAR'S SIGNATURE |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |                                  |  |  | 8 0 1 3 3 5 9   |   |  |
|---|--|---|--|---|--|--|----------------------------------|--|--|---|---|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  |   |  |   | CERTIFICATE OF DEATH   |  |                                  |  |  | REG. NO.  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Ellen Louise Moore</i>   |  |   |  |   | 2a. DATE OF DEATH  |  | MONTH                            | DAY  | YEAR                                   | 2b. HOUR  |   |  |
|   |  |   |  |   |  |  | 5                                | 3  | 80                                     | 3:15 PM   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 6, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                    |                                  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                                |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co., MD.</b>                   |                                  |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Brooke Grove Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   | 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b> |  | 13c. CITY OR TOWN<br><b>Clarksburg</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Madison Walters</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Belle Lewis</b> |  |                                  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>030-50-2982</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs George S. Friend, Item 13</b>  |  |  |                                  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>436- Cardio-vascular Accident</b><br>IMMEDIATE CAUSE (a) <b>Cardio-vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |                                  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Arteriosclerotic Heart Disease</b>  |  |   |  |   |  |  |                                  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                                  |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                  |  |  |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Jan 19 80</b> to <b>3 May 19 80</b> , that (1) (we) last saw the deceased alive on <b>28 Apr 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.   |  |   |  |   |  |  |                                  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Daniel L. Anderson</b>   |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |                                  | 22c. DATE SIGNED<br><b>5/3/80</b>  |  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daniel L. Anderson, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>18111 Prince Phillip Dr., Olney, Md.</b>   |  |  |                                  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>May 9, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Lutheran</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Centre Square, Montg., Pa.</b>      |                                  |  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Olin L. Molesworth, Damascus, Md.</b>  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>MAY 9 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Jeffrey M. Cuddy</i>                                |                                  |  |  |   |   |  |





Female

White

June 2, 1900

Leaves

U.S.A.

x

Leaves

July

Brooks Grove Nursing Home

Leaves

Leaves

Leaves

x

Leaves

Leaves

Leaves

Leaves

Leaves

Leaves

on

050-50-505

Leaves

Leaves

May 2, 1900

Leaves

Leaves

Leaves

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

13360

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |   |   |  |   |                                   |  |
|---|--|--|--|--|---|---|--|---|-----------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANCIS L. MOORE</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-28-80</b>                       |  |   | 2b HOUR<br><b>11 03</b> AM  |  |   |                                   |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 13 09</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS<br>HOURS MIN  |                                   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, D.C.</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                          |  |   |                                   |  |
| 10 CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hosp.</b> |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BUYER CLERK</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>HARDWARE STORE</b>   |                                   |  |
| 13a STATE<br><b>MARYLAND</b>  |  |  | 13b COUNTY<br><b>MONTGOMERY</b>  |  | 13c CITY OR TOWN<br><b>SILVER SPRING</b>                                      |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                                   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM GEORGE MOORE</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE MCNERHANY</b> |  |   | 13e STREET ADDRESS<br><b>11644 LOCKWOOD DRIVE</b>                                     |  |   |                                   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  | 16b SOCIAL SECURITY NO.<br><b>WW 11 578-05-2228</b>                        |  | 17 INFORMANT<br><b>MINERVA E. MOORE</b>                                       |   |  |   | ADDRESS<br><b>SAME AS 13 WIFE</b> |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5939</b> IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>red manifying</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>degs</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hours</b> |  |  |  |  |   |   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |                                   |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |                                   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |                                   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |   |                                   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>MAY 16</b> , 19 <b>80</b> , to <b>MAY 28</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>MAY 27</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (we) did not view the body after death.  |  |  |  |  |   |   |  |   |                                   |  |
| 22b SIGNATURE<br><b>Milton J Koch</b>   |  |  |  |  | DEGREE<br><b>M.D.</b>   |   |  | 22c DATE SIGNED<br><b>5/28/80</b>   |                                   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MILTON KOCH</b>  |  |  |  |  | 22e ADDRESS<br><b>201 MEDICAL PARK DRIVE<br/>SILVER SPRING, MD 20902</b>      |   |  |   |                                   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b DATE<br><b>6/2/80</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>CHELTENHAM CEMETERY</b>               |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CHELTENHAM MARYLAND</b>                        |   |                                   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>  |  |  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAY 29 1980</b>                            |   |  |   |                                   |  |
| 25b REGISTERARS SIGNATURE<br><b>Robert McCurdy</b>  |  |  |  |  | 25c REGISTERARS SIGNATURE   |   |  |   |                                   |  |

17  
168  
26  
150  
9  
9  
1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

500 UNIT RD, W. SILVER SPRING, MD. 20901

FRANCIS J. COLLINS

BURIAL

6/2/50

GREENHURST CEMETERY

WELLS

MARYLAND

*[Faint, illegible handwritten notes and signatures]*

YES    Wm 11    1578-02-2228    STEVEN E. MOORE    SAME AS 13    WIFE

WILLIAM

GEORGE MOORE

CATHERINE

HONORARY

MARYLAND    MONTGOMERY    SILVER SPRING    11844 LOCKWOOD DRIVE

SILVER CLERK

HARDWARE STORE

WASHINGTON, D.C.    U.S.A.

WIFE    WHITE

*[Faint, illegible text at the top of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 3 6 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ERIC W MORGAN</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 11 80</b>   |  | 2b. HOUR<br><b>8<sup>12</sup> A.M.</b>   |  |
| 3 SEX<br><b>Male.</b>  |  | 4 RACE<br><b>White.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Apr. 8, 1894</b>                                    |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Nanticoke, Penna.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HOLY CROSS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Auditor. Retired.</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 13b. STREET ADDRESS<br><b>7302 Willow Ave. Tak. Pk.</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel Morgan.</b>   |  |  |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Not Available.</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes.</b>   |  |  |  |
| 16b. SOCIAL SECURITY NO<br><b>579-58-0982</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Richard Morgan ( Son ) 13 e</b>  |  |  |  |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BYAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) **Cerebral ischemia**431-  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Cerebral vascular hemorrhage**

DUE TO, OR AS A CONSEQUENCE OF

(c)

7 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>May 10, 1980</b> to <b>May 11, 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>5-11-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Edward J. Richards</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5-11-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |   |  |

|  |  |                                  |  |  |  |  |  |
|--|--|----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPRINT)<br><b>Burial</b>               |  | 23b. DATE<br><b>May 14, 1980</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bladensburg Rd. P. Geo. Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JARATHUR WALTERS, 254 CARROLL STN W</b> |  | ADDRESS<br><b>WASH DC</b>        |  | 25a. DATE FILED BY REGISTRAR<br><b>MAY 14 1980</b>       |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                 |  |

James Watson, 254 Green St  
Burial

Nov 14, 1901 Ft. Lincoln

Bladenboro, N. C. Geo. W.

*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*

570-28-0882 Richard Norman (Son) 13  
Not Available

Virginia, Monticello, 1800 11th Ave. N. E.

State Street, N. E. 11th Ave. N. E.

Monticello, N. E. 11th Ave. N. E.

Monticello, N. E. 11th Ave. N. E.

Monticello, N. E. 11th Ave. N. E.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |   |  |   |  | REG. NO.  |  |
|--|--|---|--|--|--|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |   |  |  |  |   |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>BERTHA</b>   |  |   |  | FIRST <b>NMN</b>   |  | MIDDLE <b>MYLISH</b>  |  | LAST <b>MYLISH</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>27</b> YEAR <b>80</b>  |  |
| 3 SEX<br><b>female</b>   |  | 4 RACE<br><b>white</b>  |  | 5 DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>20</b> YEAR <b>1894</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>   |  | 7b. HOUR<br><b>920P</b>   |  | 7a. MONTH   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY Co.</b>  |  | 10 CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN HOSPITAL</b> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |  | 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14 FATHER'S NAME<br>FIRST <b>unknown</b> MIDDLE <b></b> LAST <b>Rosenthal</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Hanna</b> MIDDLE <b></b> LAST <b>Davis</b>                            |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO<br><b>164-09-0790B</b>  |  | 17 INFORMANT<br><b>Leon Mylish same as 13e</b>  |  | 17a. STREET ADDRESS<br><b>261 Congressional Lane #106</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>VASCULAR collapse</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>410- possible acute MI</b><br>(b) <b>acute</b><br>(c) <b>MI</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ASHD, D.M., Paraph. Vess disease C.H.F.</b> |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>acute</b>  |  |
| 19a. DATE OF OPERATION<br><b>1</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ASHD</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |
| 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>3-15</b> 19 <b>76</b> to <b>5-27</b> 19 <b>80</b> , that (I) <del>was</del> lost<br>saw the deceased alive on <b>MAY 16</b> 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above <b>16</b> <del>16</del> (did not) view the body after death. |  | 22b. DATE SIGNED<br><b>5/28/80</b>  |  |
| 22c. SIGNATURE<br><b>J.S. SAIA</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J.S. SAIA</b>   |  | 22e. ADDRESS<br><b>809 Viers n. 11 Rd. Rockville, Md.</b>  |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22g. DATE<br><b>JUN 3 1980</b>  |  | 22h. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/30/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King David Mem. Gardens</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Falls Church, Virginia</b>   |  | 24. FUNERAL DIRECTOR<br>NAME <b>Tyson Wheeler Funeral Home, Inc.</b><br>ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>JUN 3 1980</b>   |  |





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 3 6 3

|  |  |   |  |
|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Walter J. Myskowski  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>MAY 27 1980   |  |
| 3 SEX<br>Male  |  | 7b. HOUR<br>7 AM  |  |
| 4 RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug. 18, 1917  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mass.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6213 Stoneham Road  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Attorney   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Law   |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13b. STREET ADDRESS<br>6213 Stoneham Road  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Myskowski   |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Olympia Stepien  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  |
| 16b. SOCIAL SECURITY NO.<br>033-22-2166  |  | 17. INFORMANT ADDRESS<br>M. Ruth Myskowski Same as 13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>arteriosclerotic heart disease</u><br>(c) <u>generalized arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>10 years</u><br><u>10 years</u> |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><u>diabetes mellitus</u>   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                             |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>59</u> , to <u>May 27</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>May 21</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.   |  |   |  |
| 22b. SIGNATURE<br><u>W. R. F. Hermantrott</u>  |  | 22c. DATE SIGNED<br><u>5/27/80</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>W. R. F. Hermantrott</u>   |  | 22e. ADDRESS<br>11125 Rockville Pike, Rockville, Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>May 30, 1980</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gate of Heaven Cem.</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Silver Spring, Md.</u>  |  |
| 24. FUNERAL DIRECTOR NAME<br><u>Robert A. Pumphrey</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 3 1980</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Harvey McCreedy</u>   |  | 25c. ADDRESS<br><u>Homes, P.A. Bethesda, Md.</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| Item 6 g 34 6/13/80 gj<br>FOR<br>1- STATE REGISTRAR  |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Toonym N. Nalbandian  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>05 15 80   |   |  | 2b. HOUR<br>10:10 A M  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Caucasian   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>11 22 06   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>73 76 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Iran  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Rockville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Adventist Hospital |  |  |  | 12a. USUAL OCCUPATION<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |   |  |  |  |
| 13a. STATE<br>Mass.  |  | 13b. COUNTY<br>Middlesex  |  | 13c. CITY OR TOWN<br>Watertown   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>56 Chauncey St. 02172   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Unknown Mirzajanian  |  |   |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>022058748          |  | 17 INFORMANT ADDRESS<br>Anna Baker daughter 9205 Overlea Dr. Rockville, Md.  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>metastatic carcinoma to pleural</u><br>(c) <u>gastric carcinoma</u>   |  |   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immed</u><br><u>two months</u><br><u>one year</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>April 27</u> 19 <u>80</u> to <u>May 8</u> 19 <u>80</u> , that (1) (we) lost saw the deceased alive on <u>May 8</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Wilfred R. Ehirmantrant MD   |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>5/15/80  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wilfred R. Ehirmantrant   |  |   |  |  | 22c. ADDRESS<br>11125 Rockville Pike, Rockville Md   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>5-20-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ridgeland Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>at MASS.  |  | 23e. DATE REC'D. BY REGISTRAR<br>MAY 20 1980   |  |
| 24 FUNERAL DIRECTOR NAME<br>PEARSON'S FUNERAL HOME FALLS CHURCH, VA.   |  |   |  |  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

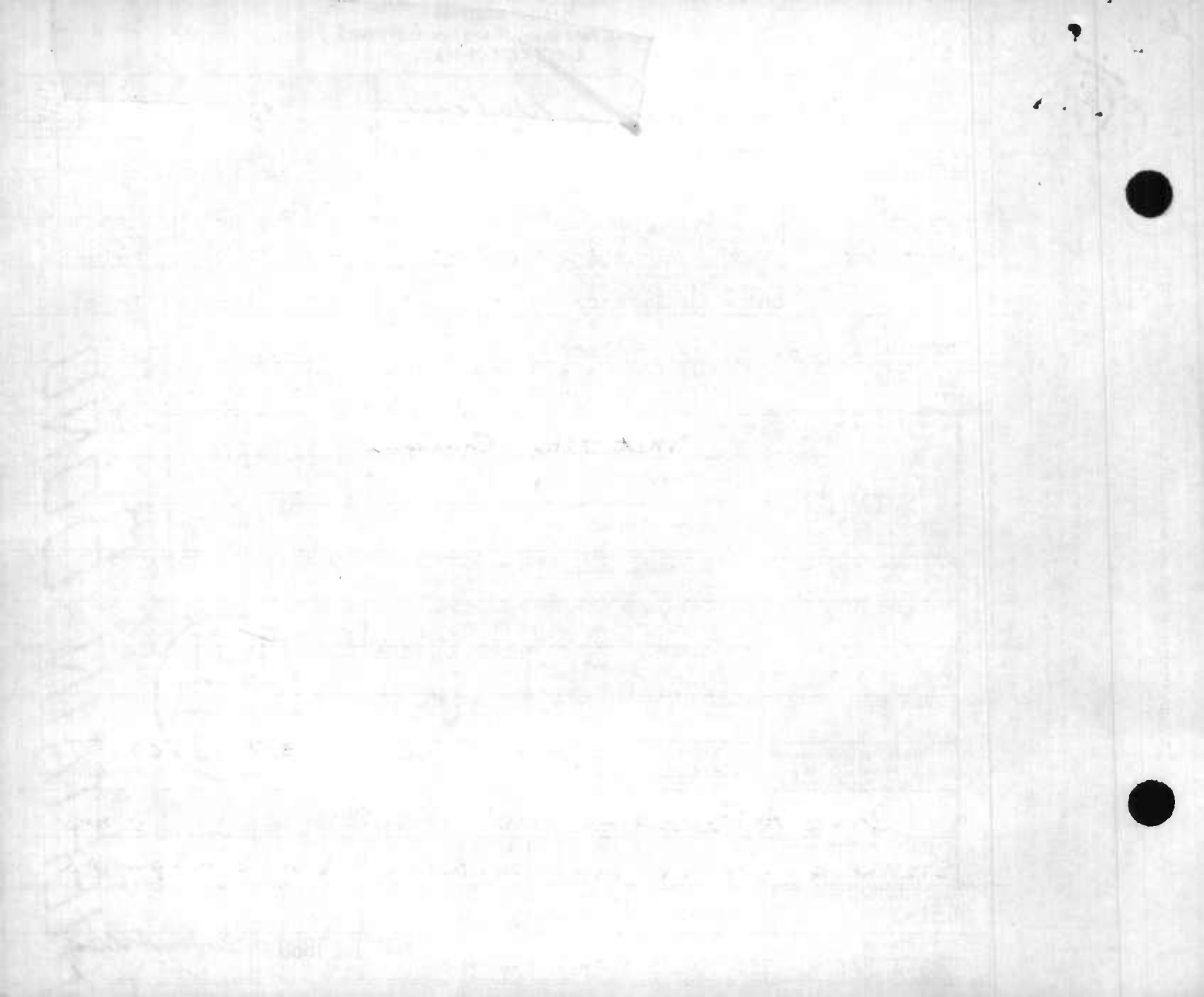
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Thomas Leon Nelson</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>May 7 80</i> |  |  | 2b. HOUR<br><i>8<sup>35</sup> a.m.</i>   |  |
| 3 SEX<br><i>Male</i>  |  | 4 RACE<br><i>Black</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 16 15</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>64</i> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>D.C.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Mont.</i> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><i>Takoma Park</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Wash, Adventist Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Custodian</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Private</i>  |  |
| 13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Mont</i>   |  | 13c. CITY OR TOWN<br><i>Wheaton</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>James A. Nelson</i>   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Emma Lewis</i>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>577-14-7780</i>   |  | 17 INFORMANT (Brother) ADDRESS<br><i>Wash., D.C.</i>   |  | 17b. <i>Ulysses Nelson 702 K. St. N.W.</i>   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-2</i> , 19 <i>80</i> , to <i>5-7</i> , 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>5-6</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Steven A. Burger</i>   |  |  |  | DEGREE<br><i>MD</i>  |  | 22c. DATE SIGNED<br><i>5-7-80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>STEVEN A. BURGER, MD</i>  |  |  |  | 22e. ADDRESS<br><i>2101 Medical Park Dr. Silver Spring, Md</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>12May80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lincoln Mem</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Suitland PG Md.</i>   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>FRAZIER'S</i>   |  |  |  | ADDRESS<br><i>389 Rhode Island Ave N.W.</i>  |  | 25 DATE RECEIVED BY REGISTRAR<br><i>MAY 16 1980</i>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |  |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  |   |  |
|--|--|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  | REG. NO.   |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>OSCAR W. NEVINS</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH <b>5</b> DAY <b>28</b> YEAR <b>80</b>                      |  |  | 2b. HOUR <b>6:30 PM</b>   |  |   |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH <b>11</b> DAY <b>28</b> YEAR <b>86</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.                               |  | 7. UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>   |  |   |  |
| 13a. STATE <b>Maryland</b>   |  |   |  |  | 13b. COUNTY <b>Montgomery</b>  |  | 13c. CITY OR TOWN <b>Silver Spring</b> |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>D.</b> LAST <b>Nevins</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Mahala</b> MIDDLE <b></b> LAST <b>Buckingham</b> |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |   |  |  | 16b. SOCIAL SECURITY NO <b>141-09-1416</b>   |  | 17. INFORMANT <b>Robert Nevins/Son</b> |   |  | ADDRESS <b>2050 Central Rd. Fort Lee, N.J.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>4291 CONGESTIVE HEART FAILURE 2 days</b> (b) <b>MYOCARDIAL DISEASE 3 years</b> (c) <b>ARTERIOSCLEROSIS 9 years</b>  |  |   |  |  |  |  |  |   |  |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>  |  |   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 78</b> to <b>5/28</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>5/28</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Thos G. Ward</b> DEGREE <b>MD</b>  |  |   |  | 22c. DATE SIGNED <b>5/28/80</b>  |  |  |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOS G. WARD</b>  |  |   |  | 22f. ADDRESS <b>6116 ROBIN WOOD, BETHESDA, 20838</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |   |  | 23b. DATE <b>May 31, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>New York Bay Cemetery</b>              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Jersey City, N.J.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Capitol Funeral Service</b> ADDRESS <b>Fairfax, Va.</b>   |  |   |  |  |  | 25a. DATE RECD. BY REGISTRAR <b>JUN 5 1980</b>                               |  | 25b. REGISTRAR'S SIGNATURE <b>notary McBrady</b>  |  |   |  |



Re

101-0-1416

Robert Nevinson

D.

Nevinson

Nebraska

2000 Central Rd.  
Brooklyn  
Fort Lee, N.J.

Nebraska

Montgomery River Bridge

X

2100 Central Rd.

Nebraska

Nebraska

New Jersey

D.H.A.

X

Nebraska

Nebraska

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  | REG. NO. 13367  |  |
|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR  |  |
| Roberta   |  | C.  |  | Newton   |  |   |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | 7. IF UNDER 1 YR.   |  | 8. IF UNDER 24 HRS.   |  |
| Female  |  | Cauc.   |  | Jan. 14, 1895  |  | 85  |  | MONTHS  |  | DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR  |  |
| Kentucky  |  | U.S.A.  |  | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | Montgomery  |  | May 5 1980  |  | 9:30 AM   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |   |  |
| Bethesda  |  | 4825 Broad Brook Dr.  |  | bookkeeper   |  | ret.  |  |   |  |   |  |
| 13a. STATE  |  | 13b. CITY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |   |  |
| Md.   |  | Montgomery  |  | Bethesda   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4825 Broad Brook Dr.  |  |   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME                                    |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |
| Bolin   |  | Corder  |  | UNKNOWN  |  | Miller  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |   |  |
| No  |  | 403-03-4650   |  | Milisse A. Haynes (Same as 13e)  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART I DEATH WAS CAUSED BY:   |  |   |  |  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>   |  |   |  |  |  |   |  |   |  |   |  |
| 411- DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |   |  |  |  |   |  |   |  |   |  |
| (b) <u>Cardio Vascular Disease</u>  |  |   |  |  |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |  |   |  |   |  |
| (c)   |  |   |  |  |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  |   |  | 20. AUTOPSY?  |  |   |  |
|   |  |   |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED   |  | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |   |  |   |  |
|   |  | HOUR A.M. MONTH DAY YEAR                                    |  |  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY  |  | STATE   |  |
|   |  |   |  |  |  |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on   |  |   |  |  |  |   |  |   |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |
| death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |  | DATE SIGNED  |  |   |  |   |  |   |  |
| John G. Ball  |  | M.D. Deputy   |  | May 5, 1980  |  |   |  |   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |  |  |  |   |  |   |  |   |  |
| John G. Ball, M.D.  |  | 7936 Old Gwtn. Rd. Bethesda, Md.                            |  |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | COUNTY  |  | STATE   |  |
| BURIAL  |  | 5-7-80  |  | Gate of Heaven Cem.  |  | Silver Spring   |  |   |  | Md.   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |   |  |
| Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland  |  | MAY 12 1980   |  | Therese McCreedy   |  |   |  |   |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  | REG. NO.  |  |
|--|--|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Robert J Northern, Jr</b>   |  |  |  |  |  | 2b. DATE OF DEATH MONTH DAY YEAR<br><b>5-13-80</b>  |  | 2c. HOUR MIN<br><b>7:28</b>                                     |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 15 17</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>                                       |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br><b>XXX</b>  |  | 8. IF UNDER 24 HRS. HOURS MIN<br><b>XXX</b>                     |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>               |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b>                        |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>C.P.A.</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Senate</b>   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN<br><b>Maryland Montgomery Sil. Spring</b>  |  |   |  | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13f. STREET ADDRESS<br><b>13408 Doncaster Lane,</b>                                |  |   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Robert J. Northern</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ellen Gifford</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b> <b>WWII</b>  |  |  |  |   |  |   |  |
| 17. SOCIAL SECURITY NO.<br><b>214-09-0403</b>  |  | 18. INFORMANT (wife)<br><b>Joan Northern- (same as 13e)</b>   |  | 19. ADDRESS<br><b>Cifford</b>  |  |  |  |   |  |   |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5304</b> IMMEDIATE CAUSE (a) <b>Boerhaaves Syndrome</b>  |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 months</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____   |  |   |  |  |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Renal Failure, Septicemia</b>   |  |   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/16/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>RUPURED ESOPHAGUS</b>  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>January 15, 1980</b> to <b>May 13, 1980</b> , that (I) (we) last saw the deceased alive on <b>May 13, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Barry Helms</b>   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>5/13/80</b>   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARRY HELMS</b>  |  | 22e. ADDRESS<br><b>10620 GEORGIA AVENUE SILVER SPRING 20902</b>   |  |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>5-13-1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Crematory Alexandria Fairfax Va.</b> |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b>  |  | 24b. REC'D BY REGISTRAR<br><b>Clark E. Wiser</b>  |  |  |  | 24c. DATE<br><b>MAY 22 1980</b>  |  | 24d. REGISTRAR'S SIGNATURE<br><b>Barry Helms</b>  |  |   |  |
| 24e. ADDRESS<br><b>8434 Ga. Ave., S.S. Md.</b>   |  |   |  |  |  |  |  |   |  |   |  |

W. E. B. DuBois

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE<br>REGISTRAR  |  |                      |  |   |  |   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE,<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 13369          |  |
|---|--|----------------------|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PAULINE A. NOWLAN</b>  |  |                      |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>5-16-1980</b> |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>8:00 PM</b> |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Jan 24 1914</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>66 YRS.</b>              |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN  |  | 2c. DATE PRONOUNCED DEAD <b>5-16-1980</b>                  |  | 2d. HOUR <b>8:00 PM</b>  |  |  |  |  |  |                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Nebraska</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD. |  |  |  |  |  |  |  |                         |  |
| 10. CITY OR TOWN OF DEATH <b>Wheaton</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>12202 Bushey Drive</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired R.N.</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>        |  |  |  |  |  |  |  |                         |  |
| 13a. STATE <b>Maryland</b>  |  |                      |  |   |  |   |  |  |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Wheaton</b>                           |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>12202 Bushey Drive,</b> |  |  |  |                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Clarence S. Peterson</b>  |  |                      |  |   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Ruth Norseen</b>   |  |  |  |  |  |  |  |  |  |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>579-58-5804</b>   |  |   |  | 17. INFORMANT (sister) <b>Lois N. Berndt-Mo.</b>   |  |   |  | ADDRESS <b>Rt. 1 Peace Valley, 65788</b>                   |  |  |  |  |  |  |  |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Right Breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost.<br>(b)<br>(c)  |  |                      |  |   |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                         |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |  |  |  |                         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |  |  |  |  |  |  |                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |  |  |  |  |                         |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                         |  |
| ACTUAL SIGNATURE <b>Richard L. Whelton</b>  |  |                      |  |   |  |   |  |  |  | TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>May 17, 1980</b>  |  |  |  |  |  |                         |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>RICHARD L. WHELTON</b>   |  |                      |  |   |  |   |  |  |  | ADDRESS <b>7100 Baltimore Ave College Park</b>  |  |  |  |  |  |  |  |  |  |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                      |  | 23b. DATE <b>5-19-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b> |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Rockville Montgomery Md.</b>  |  |  |  |  |  |  |  |  |  |                         |  |
| 24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>  |  |                      |  |   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 22 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Anthony M. Brady</b>         |  |  |  |  |  |  |  |                         |  |
| 8434 Ga. Ave., S.S. Md.   |  |                      |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |                         |  |

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| FOR<br>1- STATE<br>REGISTRAR   |         | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH    |                                    | 0 1 3 3 7 0<br>REG. NO.  |  |
|--|---------|--|------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST MIDDLE LAST  |                                    | 2a. DATE KNOWN OF DEATH ESTI- MATED  |  |
| Rogar Lawrence Odette, Sr.   |         |  |                                    | MONTH DAY YEAR<br>5/13 1980  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS<br>LAST BIRTHDAY) | 7. DATE PRONOUNCED DEAD  | 2b. HOUR P. M.                               |
| Male   | White   | Nov. 24, 1926  | 53 YRS.                            | 5/14 1980  | 11:30 P. M.                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Massachusetts  |         | U.S.A.   |                                    | Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Olney  |         | 3420 Queen Mary Drive  |                                    | Ret. Owner   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |         | 13a. STREET ADDRESS  |                                    | 13b. COUNTY  |  |
| Truck Dealer   |         | 3420 Queen Mary Drive  |                                    | Montgomery   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |                                    | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>(IF YES, GIVE WAR OR DATES) |  |
| Lewis Edward Odette  |         | Azilee Bottume   |                                    | yes WWII   |  |
| 16b. SOCIAL SECURITY NO.   |         | 17. INFORMANT  |                                    | 17. ADDRESS  |  |
| 032-16-0993  |         | Joan L. Odette (same as 13e)   |                                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |  |                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>None</u>   |         |  |                                    |  |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    | 20. AUTOPSY?   |  |
| None   |         |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                        |  |
|  |         |  |                                    | None   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
|  |         |  |                                    |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |                                    |  |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |                                    | DATE SIGNED  |  |
|  |         | Deputy   |                                    | 5/14/80  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS  |                                    |  |  |
| John S. Rogers, M.D.   |         | 1919 Seminary Road<br>Silver Spring, Montgomery, Md.   |                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |                                    | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |         | 5-17-80  |                                    | GATE OF HEAVEN CEMETERY  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |         | 25a. DATE REC'D. BY REGISTRAR  |                                    | 25b. REGISTRAR'S SIGNATURE   |  |
| ROBERT A. PUMPHREY FUNERAL HOMES P/A<br>ROCKVILLE MD.  |         | MAY 22 1980  |                                    |  |  |

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John L. (son of J. L.)

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 13371

OR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |   |  |
|---|--|--|---|---|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDWARD F. O'FLAHERTY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/24/80</b> |   |  | 2b. HOUR<br><b>1:05 AM</b>  |  |   |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 10 08</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>YRS.</b>   |  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |  | 9 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b>                              |  |   |  |
| 12 CITY OR TOWN OF DEATH<br><b>WHEATON</b>  |  | 13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Randolph Hills Nsg Home</b> |   |   |  | 14 USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LITHOGRAPHER</b>         |  | 15 KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOVT. RET.</b>   |  |
| 16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |  |   |  |   |  |
| 17a. STATE<br><b>MARYLAND</b>   |  | 17b. COUNTY<br><b>Bethesda</b>   |   | 17c. CITY OR TOWN<br><b>MD</b>  |  | 18 INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 19 STREET ADDRESS<br><b>7401 West Lake Terrace</b>  |  |
| 14 FATHER'S NAME<br>MIDDLE<br><b>FRANCIS O'FLAHERTY</b>   |  |  |   |   | 15 MOTHER'S MAIDEN NAME<br>MIDDLE<br><b>MARGARET SMALL</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO<br><b>172-24-5672A</b>   |   | 17 INFORMANT ADDRESS<br><b>MARIE A. O'FLAHERTY (SAME AS 13c)</b>  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE CARCINOMA OF LEFT LUNG</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>WEEKS</b> |  |  |   |   |  |   |  | 19  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>ORGANIC BRAIN SYNDROME, EMPHYSEMA</b>  |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I (this hospital) attended the deceased from <b>JAN 10</b> 19 <b>80</b> , to <b>MAY 24</b> 19 <b>80</b> , that I (we) last saw the deceased alive on <b>MAY 24</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.  |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Stephen J. Williams MD</b>   |  |  |   | 22c. DATE SIGNED  |  |   |  | 22d. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEPHEN J. WILLIAMS, MD</b>   |  |  |   | 22f. ADDRESS<br><b>1712 EYE ST NW WASHINGTON, DC</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5-28-80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SILVER SPRING MONTG. MD.</b>                 |  |   |  |
| 24 FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY FUNERAL HOMES P/A</b>  |  |  |   | 25. ADDRESS<br><b>ROCKVILLE MD.</b>   |  | 26. BY<br><b>JUN 3 1980</b>   |  | 27. BY<br><b>JUN 3 1980</b>   |  |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

ROBERT A. PUTNEY, BURIAL HOMES PVA

ROCKVILLE

JUN 3 1980

DEPTAL 8-28-80 GATE OF HEAVEN CEM. SILVER SPRING MONT. MD.

STEPHEN L. WILKINS (M)

115 EYE ST NW WASHINGTON DC

WILKINS

MAY 28 1980 MAY 28 1980

CHURCH OF THE HOLY TRINITY, EMPHATICALLY

PROTESTANT CHURCH OF THE HOLY TRINITY  
WEEKS

175-24-2523A MARIE A. DIFFAINTY (SAME AS 136)

FRANCIS DIFFAINTY MARGARET SHALL

ARMY AND NAVY DEPT. 101 X  
LITIGANT U.S. GOVT. RET.

RECEIVED A 0 24  
MAY 28 1980

DEPTAL 8-28-80

3 2 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 80  |   | 13372   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Thomas R. PAGEL   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 11 1980  |  |  | 2b. HOUR<br>905P M   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>March 25 1980  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br>1 16                           |  | 7. IF UNDER 1 YEAR<br>HOURS MIN<br>16  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Philippines   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13. STATE OF the Philippines   |  |   |   |   | 13b. CITY OR TOWN<br>Olongapo  |  | 13c. STREET ADDRESS<br>28 8th Street                               |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Kenneth R. Pagel  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Marietta Cabanero  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>N/A   |  |   |   |   | 16b. SOCIAL SECURITY NO.<br>N/A  |  | 17. INFORMANT ADDRESS<br>Kenneth R. Pagel See item 13              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>7689<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CENTRAL NERVOUS SYSTEM HEMORRHAGE</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>NEONATAL ASPHYXIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |
| 22a. I certify that I (this hospital) attended the deceased from May 11 1980 to May 11 1980, that I (we) last saw the deceased alive on May 11 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.)   |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br>LCDR Robert B. North USN DO.   |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>May 12 1980  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LCDR Robert North MC USN DO.  |  |   |   |   | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, Md.   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Sam Houston   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>San Antonio Bexar Texas |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>Metropolitan Funeral Service Alexandria, Va.  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 16 1980   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |

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FROM: [illegible]  
SUBJECT: [illegible]  
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THOMAS J. YAM



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>BERTHA (NMN) PAGRACH</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>May</b> Day <b>30</b> Year <b>1980</b> |   |  | 2b. HOUR <b>12:20</b> <sup>A</sup> <sub>M</sub>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Aug., 5, 1903</b>  |  | 6. AGE (In years last birthday)<br><b>76</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Netherlands</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Holy Cross</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Ret.- Companion</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>First <b>Moses</b> Middle <b>Pagrach</b> Last <b>Jacoba Schaap</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Jacoba</b> Middle <b>Schaap</b> Last <b>Schaap</b>           |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) <b>No</b> (If yes give war or dates of service) <b>None</b>                               |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>071-30-6589</b>  |  | 17. INFORMANT <b>Kensington, Md. 20795</b><br><b>Meyer Schwarz-friend 3505 Stark St.</b>          |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br><b>1629</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>BRONCHIOALVEOLAR CARCINOMA</b><br>(b) <b>6 mo's</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                           |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>weeks</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><b>P.M. 19</b>                                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 19 80</b> , to <b>MAY 30, 19 80</b> , that (I) <del>(we)</del> <sup>(we)</sup> saw the deceased alive on <b>MAY 29 19 80</b> , and that in (my) <del>(our)</del> <sup>(our)</sup> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <sup>(we)</sup> <del>(did)</del> (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Daniel Rosenthal</b>   |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>5/30/80</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DANIEL ROSENTHAL</b>   |  |   |  | 22e. ADDRESS<br><b>10400 CONNECTICUT AV KENSINGTON, MD 20795</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>5-30-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>300 4th St. N.E. Wash.D.C.</b>           |  |
| 24. FUNERAL DIRECTOR<br><b>Lee Funeral Home 300-4th St.N.E. Wash.D.C. 20002</b>   |  |   |  | 25a. JUDICIAL REGISTRAR<br><b>JUNE 1 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 1 3 3 7 4   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PLATO PAPPS   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 29, 1980   |  | 2b. HOUR<br>8:00 A.M.  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 15 1917  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Michigan  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>CHEVY CHASE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4701 WILLARD AVE. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Attorney  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Labor Union Council   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Chevy Chase   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ernest N Papps   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Iphigenia Maktos   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII   |  | 17. INFORMANT<br>ADDRESS<br>Helen H Papps, Wife. Same as item 13/  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Disease of Hypertension</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 hours</u><br><u>8 years</u> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>① Aortic Aneurysm ② Calcified coronary arteries</u>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>April 17, 1980   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Aortic Aneurysm  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 11, 1980</u> to <u>May 20, 1980</u> , that (I) (we) last saw the deceased alive on <u>May 19, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>John R. Ewan MD</u>   |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>5/29/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN R. EWAN, MD  |  |  |  | 22e. ADDRESS<br>946 19th St N.W.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE CITY)<br>Cremation   |  | 23b. DATE<br>5/30/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Md.  |  |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.<br>NAME ADDRESS<br>5130 Wisc. Ave., N.W. Wash., D.C.  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br>JUN 3 1980  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |   |  |                                    |   |                                     |  |   | 8013375   |  |
|--|--|------------------------------|---|--|------------------------------------|---|-------------------------------------|--|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |                              | REG. NO.  |  |                                    |   |                                     |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              | 2a. DATE OF DEATH   |  |                                    | MONTH DAY YEAR  |                                     |  | 2b. HOUR  |   |  |
| George A. Patrick  |  |                              | K 5 19 80   |  |                                    | 16 55 M   |                                     |  |   |   |  |
| 3 SEX  |  | 4 RACE                       |   | 5 DATE OF BIRTH  |                                    |   | 6 AGE (IN YEARS LAST BIRTHDAY)      |  |   | 7a. IF UNDER 1 YEAR                             |  |
| Male   |  | Caucasian                    |   | 3 15 1901  |                                    |   | 79 YRS.                             |  |   | MONTHS DAYS HOURS MIN                           |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7c. CITIZEN OF WHAT COUNTRY? |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |   | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |   |   |  |
| California   |  | U.S.A.                       |   |  |                                    |   | Montgomery County MD                |  |   |   |  |
| 10 CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |   |  |
| Bethesda   |  |                              | Suburban Hospital   |  |                                    | Analyst   |                                     |  | U.S. Gov't.   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                              |   |  |                                    | 13b. INSIDE CITY LIMITS?  |                                     | 13c. STREET ADDRESS                        |   |   |  |
| 13a. STATE 13b. COUNTY   |  |                              |   |  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                     | 3206 Leland Street                         |   |   |  |
| Maryland Montgomery  |  |                              |   |  |                                    |   |                                     |  |   |   |  |
| 14 FATHER'S NAME   |  |                              |   |  |                                    | 15 MOTHER'S MAIDEN NAME   |                                     |  |   |   |  |
| 14a. FIRST 14b. MIDDLE 14c. LAST   |  |                              |   |  |                                    | 15a. FIRST 15b. MIDDLE 15c. LAST  |                                     |  |   |   |  |
| John Patrick   |  |                              |   |  |                                    | UNKNOWN   |                                     |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |                              |   |  |                                    | 16b. SOCIAL SECURITY NO   |                                     | 17 INFORMANT ADDRESS                       |   |   |  |
| No   |  |                              |   |  |                                    | 217-44-0172   |                                     | Laura A. Patrick, same as #13              |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.  |  |                              |   |  |                                    |   |                                     |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Uremia   |  |                              |   |  |                                    |   |                                     |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis - general  |  |                              |   |  |                                    |   |                                     |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                              |   |  |                                    |   |                                     |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |                              |   |  |                                    |   |                                     |  |   |   |  |
| Congestive heart failure + cardiac fibrillation  |  |                              |   |  |                                    |   |                                     |  |   |   |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                    | 20a. AUTOPSY?   |                                     |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |  |
|  |  |                              |   |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                     |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                     |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/19/80 to present 1980, that (II) (we) lost<br>saw the deceased alive on 5/19/80, and that (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I/we) did (did not) see the body after death. |  |                              |   |  |                                    |   |                                     |  |   |   |  |
| 22b. SIGNATURE   |  |                              |   |  |                                    | DEGREE  |                                     |  | 22c. DATE SIGNED  |   |  |
| John B. Umhau MD   |  |                              |   |  |                                    | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN DIRECTOR PHYSICIAN |                                     |  | 5/19/80   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              |   |  |                                    | 22e. ADDRESS  |                                     |  |   |   |  |
| John B. Umhau  |  |                              |   |  |                                    | 8805 Conn. Ave. Chevy Chase Md.   |                                     |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |                              | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |   |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |   |  |
| Cremation  |  |                              | May 21, 1980  |  | Metropolitan Crem.                 |   |                                     | Alexandria, Virginia                       |   |   |  |
| 24 FUNERAL DIRECTOR<br>Robert A. Pumphrey Funeral Homes, P.A. MAY 21 1980  |  |                              |   |  |                                    |   |                                     |  |   |   |  |
| 7557 Wisconsin Avenue, Bethesda, MD  |  |                              |   |  |                                    |   |                                     |  |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO.                          |  |
|---|--|--|--|--|--|--|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>William Roy Peifer</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5 5 80</i>                   |  |  | 2b. HOUR<br><i>7 AM</i>  |  |  |  |                                   |  |
| 3 SEX<br><i>Male</i>  |  | 4 RACE<br><i>white</i>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 8 13</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>66</i>  |  | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS<br><i>YRS.</i>  |  | 7b. IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>  |  | 7d. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                         |  |  |  |                                   |  |
| 10 CITY OR TOWN OF DEATH<br><i>Rockville</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Rockville Nursing Home</i> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>retired</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Ser. Tech. TRW</i>   |  |                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. CITY OR TOWN 13c. INSIDE CITY LIMITS?<br><i>Maryland Montgomery Rockville</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13d. STREET ADDRESS<br><i>14004 Cove Lane #304</i>   |  |  |  |  |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>George Calvin Peifer</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Jessie Levine Williams</i>   |  |  |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>yes</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>WW II</i>  |  | 17 INFORMANT<br><i>15313 Okinawa Avenue</i><br><i>Kenneth R. Peifer Rockville, Maryland</i>  |  |  |  |  |  |                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinomatosis</i><br><i>1729</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Malignant Melanoma</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>4 mos.</i><br><i>10 mos.</i>   |  |  |  |  |  |  |  |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |  |  |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |                                   |  |
| 22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <i>4/28</i> 19 <i>80</i> , to <i>5/1</i> 19 <i>80</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>4/28</i> 19 <i>80</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. |  |  |  |  |  |  |  |  |  |                                   |  |
| 22b. SIGNATURE<br><i>W. G. Hall</i>   |  |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>W.G. Hall</i>              |  |  | 22d. ADDRESS<br><i>615 W. Montgomery Ave. Rockville, Md.</i>                         |  |  | 22e. DATE SIGNED<br><i>5/5/80</i>  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  |  | 23b. DATE<br><i>5/8/80</i>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arlington National Cemetery</i>             |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Arlington, Virginia</i> |                                   |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Tyson Wheeler Funeral Home, Inc.<br/>1331 Rockville Pike Rockville, Maryland</i>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 12 1980</i>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Brady</i>   |  |                                   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 3 3 7 7

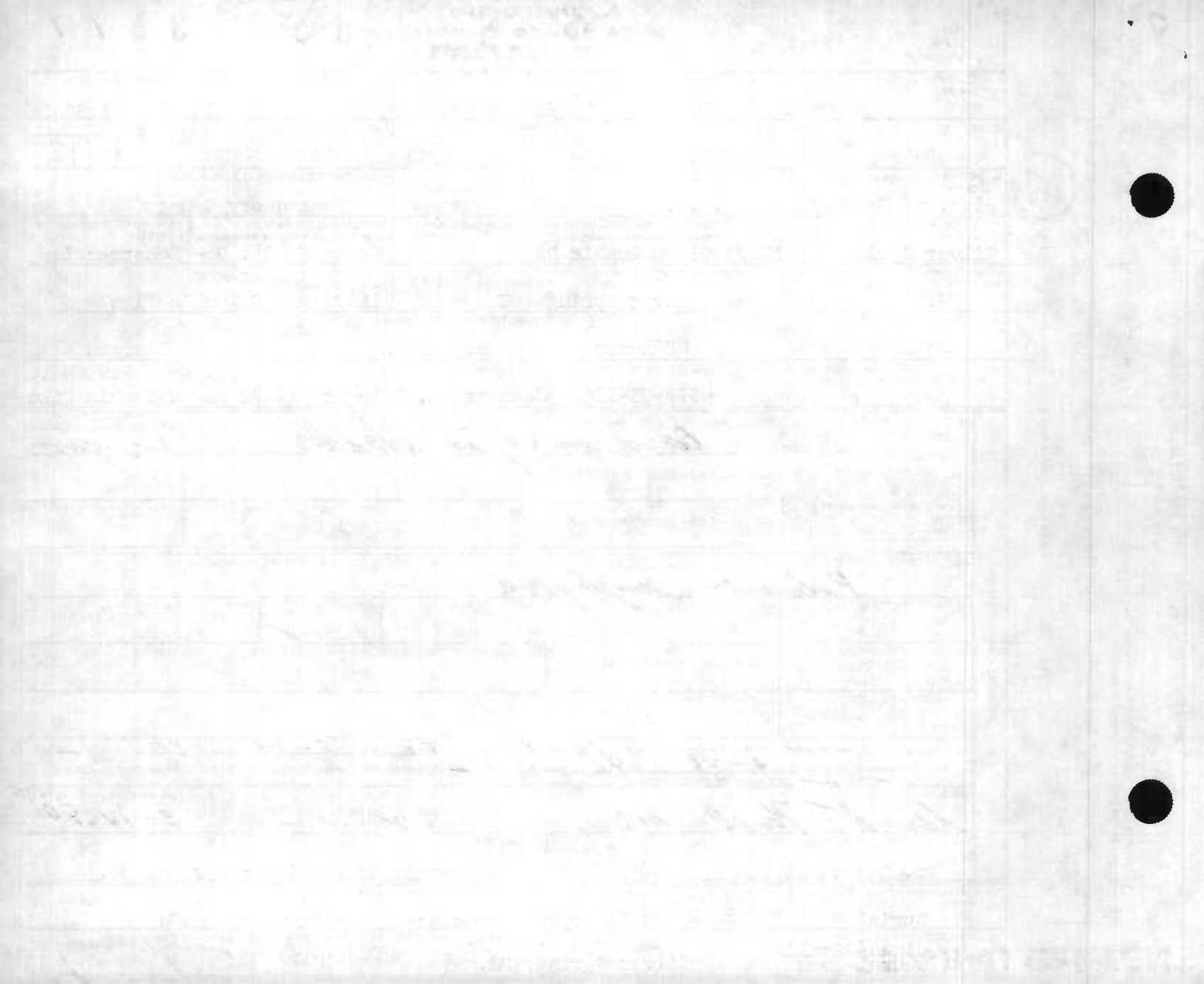
1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |  |  |   |   |  |
|--|--|---|---|--|--|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lawrence L. Pfluger</b>     |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 14, 1980</b>                 |  |  | 2b HOUR<br><b>1:30 AM</b>  |  |   |   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 24 1904</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>00 00</b>        |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Dist. of Columbia</b> |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>  |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>11473 Old Columbia Pike</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Heavy Equip. Op-</b>                   |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b> |   |  |
| 13a STATE<br><b>Md.</b>  |  |   | 13b COUNTY<br><b>Mont. Co.</b>  |  | 13c CITY OR TOWN<br><b>Silver Spring</b> |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS<br><b>erator<br/>11473 Old Columbia Pike</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Pfluger</b>         |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ellen Kiernan</b> |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  |   |   |  |
| 16b SOCIAL SECURITY NO<br><b>578-03-1946</b>                         |  |   | 17 INFORMANT<br><b>Jeanette L. Pfluger</b>                                |  |  | ADDRESS<br><b>Apt. C-5, S.S. Md.<br/>11473 Old Columbia Pike</b>   |  |   |   |  |

|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the bladder</b><br><b>1889</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 years</b>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Pulmonary emphysema</b>  |  |   |  |   |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a I certify that (I) ( <del>was</del> <b>was</b> ) attended the deceased from <b>10-6</b> , 19 <b>78</b> , to <b>5-14</b> , 19 <b>80</b> , that (I) ( <del>was</del> <b>was</b> ) last saw the deceased alive on <b>4-26</b> , 19 <b>80</b> , and that in (my) ( <del>my</del> <b>my</b> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> <b>did</b> ) view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b SIGNATURE<br><b>Alvin T. Kimble MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | 22c DATE SIGNED<br><b>5-14-80</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Seruch Kimble</b>  |  |   |  | 22e ADDRESS<br><b>9801 Georgia Ave., Silver Spring, Md.</b>                   |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>May 16, 1980</b>                                       |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>               |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland P.G. Md.</b>               |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Hines/Rinaldi</b>   |  |   |  | ADDRESS<br><b>11800 N.H.Ave.<br/>Silver Spring, Md.</b>                       |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAY 19 1980</b>                                  |  | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  | REG. NO. 8 0 1 3 3 7 8  |   |   |   |  |
|--|--|--|---|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |   |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORA ROBERTS PICKERING  |  |  |   |  | MAY 23, 1980  |   |   |   |  |
| 3 SEX FEMALE   |  |  |   |  | 2b. HOUR 2125 P.M.  |   |   |   |  |
| 4 RACE CAUCASIAN   |  |  |   |  | 6 AGE [IN YEARS LAST BIRTHDAY] 85                                       |   |   |   |  |
| 5 DATE OF BIRTH MONTH DAY YEAR SEPT. 9, 1844   |  |  |   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI                    |   |   |   |  |
| 8 CITIZEN OF WHAT COUNTRY? USA   |  |  |   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.               |   |   |   |  |
| 10 CITY OR TOWN OF DEATH BETHESDA, NAT'L NAVAL MEDICAL CENTER  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE |   |   |   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY Home                                  |   |   |   |  |
| 13a. STATE D.C. WASHINGTON   |  |  |   |  | 13b. CITY OR TOWN WASHINGTON  |   |   |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST JOHN W. ROBERTS   |  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA SIVLEY                   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  |  |   |  | 16b. SOCIAL SECURITY NO 579-60-7992                                     |   |   |   |  |
| 17 INFORMANT ADDRESS MARY C. ROBERTS SISTER  |  |  |   |  | SAME AS ITEM 15   |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                            |   |   |   |  |
| 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |   |  |   |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |   |  |   |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |
| 22a. I certify that I (this hospital) attended the deceased from 1830 17 MAY 19 80 to 2125 23 MAY 19 80, that I (we) last saw the deceased alive on 23 MAY 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death. |  |  |   |  |   |   |   |   |  |
| 22b. SIGNATURE M. H. Vernalis  |  |  |   |  | DEGREE  |   |   | 22c. DATE SIGNED 24 MAY 1980  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.H. VERNALIS MD   |  |  |   |  | 22e. ADDRESS NAT'L NAVAL MEDICAL CENTER, BETHESDA, MD.                  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |  | 23b. DATE 5/28/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM               |   | 23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, VIRGINIA |   |  |
| 24 FUNERAL DIRECTOR Joseph Gawler's Sons Inc. NAME ADDRESS 5130 Wisc. Ave., N.W. Wash., D. C.  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR MAY 29 1980                               |   | 25b. REGISTRAR'S SIGNATURE [Signature]                      |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |  |  |                                    |  |
|---|--|---|--|---|--|---|--|--|--|--|--|------------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 80 13379   |  |   |  |   |  |  |  |  |  |                                    |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                 |  | 2b. HOUR   |  |                                    |  |
| ROBERT T. PICKETT   |  |   |  |   |  |   |  | 5 10 80  |  | 2:17 P.M.  |  |                                    |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |                                    |  |
| MALE  |  | White   |  | MONTH DAY YEAR<br>1 3 06  |  | 74 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.   |  |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |                                    |  |
| Arkansas  |  | USA   |  |   |  | MONTGOMERY MD.  |  |  |  |  |  |                                    |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |                                    |  |
| SILVER SPRING   |  | HOLY CROSS HOSPITAL   |  |   |  |   |  | Chemist  |  | Paint Co.  |  |                                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |  |  |  |                                    |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |                                    |  |
| Md.   |  | Mont  |  | Silver Spring   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 9405 Bruce Drive   |  |  |  |                                    |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |  |  |  |  |                                    |  |
| FIRST MIDDLE LAST   |  |   |  | FIRST MIDDLE LAST   |  |   |  |  |  |  |  |                                    |  |
| James Pickett   |  |   |  | Ida Hadley  |  |   |  |  |  |  |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  |   |  | 17. INFORMANT ADDRESS  |  |  |  |                                    |  |
| No  |  |   |  | 578-03-2677   |  |   |  |  |  |  |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory failure</u><br>496-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>severe chronic obstructive lung disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |  |  |                                    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |                                    |  |
|   |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |  |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |                                    |  |
|   |  |   |  |   |  |   |  |  |  |  |  |                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5/10/80</u> to <u>5/11/80</u> , that (1) (we) last saw the deceased alive on <u>5/10/80</u> , 19 <u>80</u> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  | 22b. SIGNATURE<br><u>Eliot R. Goldstein</u> MD<br>DEGREE |  | 22c. DATE SIGNED<br><u>5/11/80</u> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ELIOT R. GOLDSTEIN</u>  |  |   |  |   |  |   |  |  |  | 22e. ADDRESS<br><u>9410 OLD GEORGETOWN RD BETH. MD.</u>  |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY   |  | STATE  |  |                                    |  |
| Removal   |  | 5-11-80   |  |   |  |   |  |  |  |  |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Anatomy Board</u>  |  |   |  |   |  | ADDRESS<br><u>Balto., Md.</u>                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAY 14 1980</u>              |  | 25b. REGISTRAR'S SIGNATURE<br><u>Lillian M. Brady</u>    |  |                                    |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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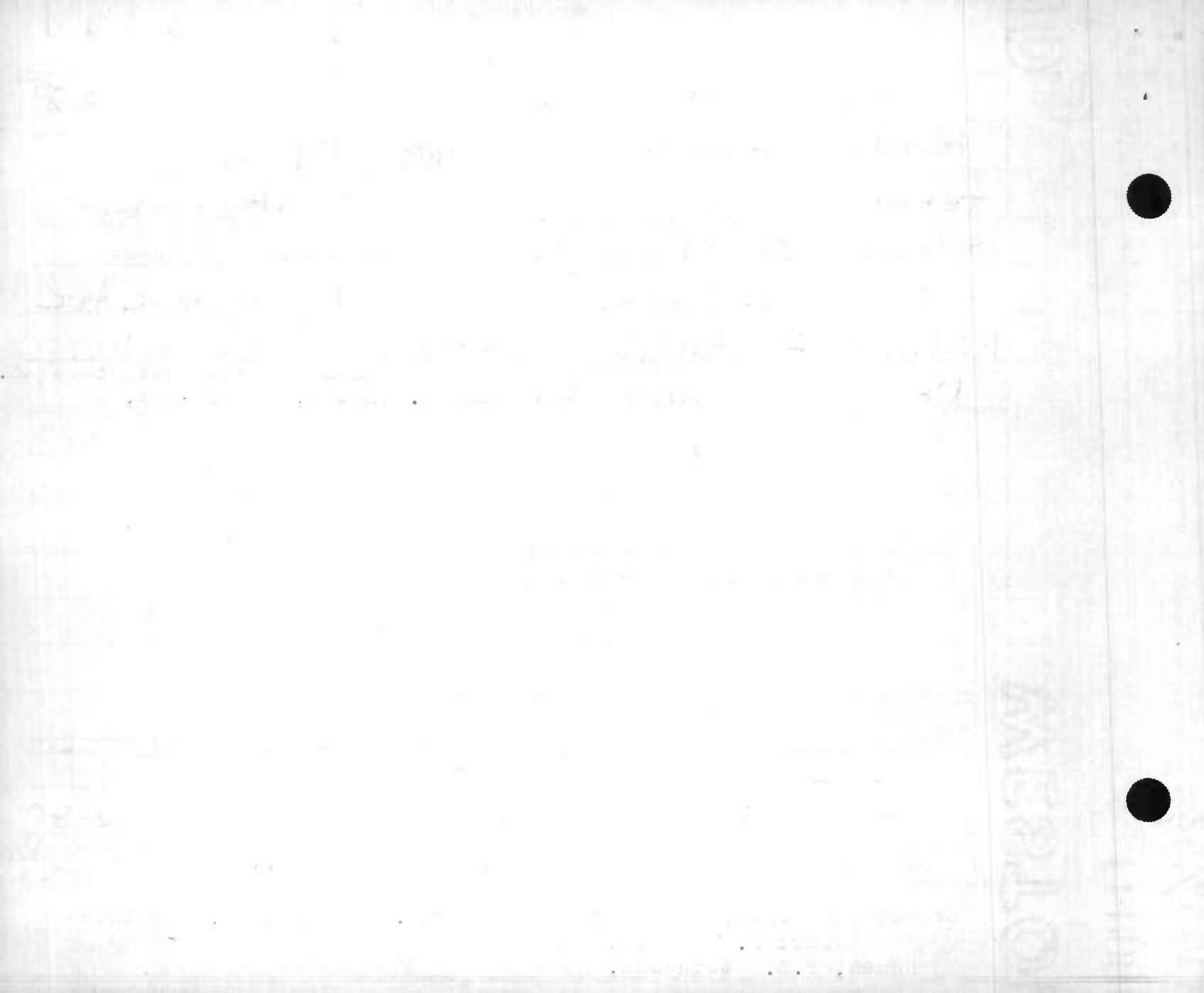
1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |  |  |  |   |  |
|---|--|---|--|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Alberta  |  | MIDDLE<br>N   | LAST<br>Picton  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5-22-80         |  |  | 2b. HOUR<br>12 25 AM  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 12 1908  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.             |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tenn   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD. |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8305 Old Georgetown Rd |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   |  |   |   | 13b. COUNTY<br>Mont.   |  | 13c. CITY OR TOWN<br>Beth  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard A. Harris   |  |   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elta Eubanks                        |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>215-48-0651   |  | 17. INFORMANT<br>8305 ADDRESS Old Georgetown Rd.<br>Nancy E. Picton, Bethesda, MD   |   |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC HEART DISEASE 5 years<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)         |  |   |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 MMS.  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>METASTATIC CARCINOMA OF PANCREAS  |  |   |  |   |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET   |   | CITY OR TOWN   |  | COUNTY   |  | STATE   |  |
| 22a. I certify that (I) (saw) <del>viewed</del> attended the deceased from <u>Sept</u> 19 <u>73</u> to <u>May</u> 19 <u>80</u> , that (I) <del>lost</del> saw the deceased alive on <u>5-19</u> 19 <u>80</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) (saw) <del>viewed</del> view the body after death. |  |   |  |   |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br>John T. Tauter  |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   |  |  | 22c. DATE SIGNED<br>5-22-80  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Tauter  |  | 22e. ADDRESS<br>8218 Wisconsin Ave Bethesda MD.   |  |   |   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>5/22/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem.  |   | 23d. LOCATION<br>CITY OR TOWN<br>Alexandria  |  | COUNTY<br>Virginia   |  | STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, MD   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 29 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |

MEDICAL CERTIFICATION







Items 5 and 6 g544 6/13/80 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 3 8 1

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RICHARD PIPPEL</b>  |   | 2a. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>2</b> YEAR <b>80</b>   |   | 2b. HOUR<br><b>9<sup>15</sup> PM</b>  |   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>Jan.</b> DAY <b>24</b> YEAR <b>1927</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>D.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>Md.</b> COUNTY <b>Montgomery</b> CITY OR TOWN <b>Rockville</b> |   | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13c. STREET ADDRESS<br><b>10201 Grosvenor Place</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>Harold</b> MIDDLE <b>William</b> LAST <b>Pippel</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Frances</b> MIDDLE <b>Meany</b> LAST <b>Meany</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>WWII</b>   |   | 17. INFORMANT<br>ADDRESS <b>Rockville, Md. 20855</b><br><b>William H. Pippel 6508 Pilgrims Cove</b> |   |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>coronary artery disease</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min</b><br><b>12 hrs.</b><br><b>year</b> |
|--|--|--|

|   |  |  |  |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/2</b> 19 <b>80</b> to <b>4/2</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/2</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Samuel D. Goldberg, M.D.</b>   |  | 22c. DATE SIGNED<br><b>4-2-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Samuel D. Goldberg, M.D.</b>  |  | 22e. ADDRESS<br><b>11125 Rockville Pike, Rockville, Maryland</b>               |  |

|  |                              |   |  |
|--|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>4/5/1980</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b> | 23d. LOCATION<br>CITY OR TOWN <b>Rockville, Maryland.</b> COUNTY STATE |
| 24. FUNERAL DIRECTOR<br>NAME <b>Joseph Gawler's Sons Inc.</b> ADDRESS <b>5130 Wisconsin Ave., N.W. Wash., D.C.</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 8 1980</b>                  | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. Kelly</b>                       |

Released by Dr. John Ball, Deputy Medical Examiner

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

waived by Dr. Ball

RECEIVED BY MR. L. J. HALL, DEPT. OF MEDICAL EXAMINER

MAILED



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

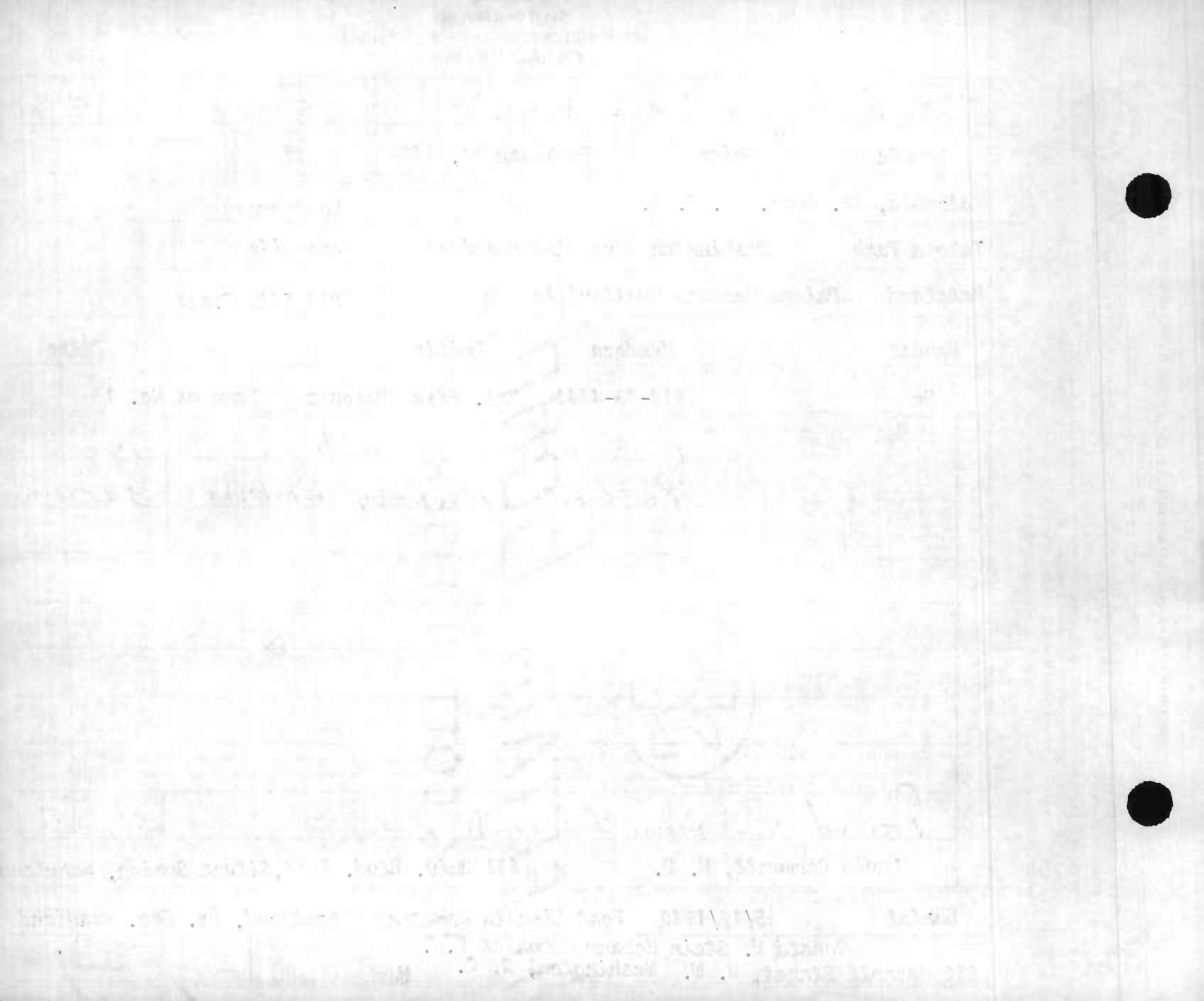
REG. NO.

|   |  |   |  |   |   |  |   |   |  |
|---|--|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bernarda Jesus Pitre</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05-09-1980</b>               |   |   | 2b. HOUR<br><b>8<sup>20</sup> P.M.</b>   |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 26, 1898</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Colombia, So. Amer.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE WORK FORMERLY OF WORKING LIFE)<br><b>Housewife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><b>Maryland Prince Georges Hyattsville</b>  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5014 54th Place</b>                                     |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Manuel Mendoza</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emilia Pitre</b>                            |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-76-4441</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Elsa Vasquez Same as No. 13</b>   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Possible Pulmonary Embolus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min.</b><br><b>30 min.</b> |  |   |  |   |   |  |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |   |   |  |
| 22b. SIGNATURE<br><b>David Cromwell</b> MD  |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/10/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David Cromwell, M. D.</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>831 Univ. Blvd. East, Silver Spring, Maryland</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>5/12/1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, Pr. Geo. Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Donald M. Stein Hebrew Memorial F.H.</b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 12 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>   |  |
| 26. ADDRESS<br><b>232 Carroll Street, N. W. Washington, D. C.</b>   |  |   |  |   |   |  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |  |  |  |   |   |  |   |  | REG. NO. 13383                               |  |
|---|----------------------|--|--|--|---|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |                      | DECEASED NAME (TYPE OR PRINT) <b>KATHRYN VIRGINIA PLATT</b>  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>5</b> DAY <b>25</b> YEAR <b>1980</b>  |   | 2b. HOUR <b>6</b> AM  |  |   |  |  |  |
| 3. SEX <b>Female</b>  | 4. RACE <b>White</b> | 5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>2</b> YEAR <b>1964</b>  | 6. AGE (IN YEARS) LAST BIRTHDAY <b>15</b> YRS. | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD <b>5/25</b> 19 <b>80</b>                               |  | 2d. HOUR <b>6</b> AM  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY Co. MD</b>                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>BETHESDA</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSP</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>                                |  |  |  |
| 13a. STATE <b>Md.</b>   |                      |  |  | 13b. COUNTY <b>Mont.</b>   |   | 13c. CITY OR TOWN <b>Bethesda</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>7508 Hampden Lane</b> |  |
| 14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>D.</b> LAST <b>Platt III</b>   |                      |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b>-</b> LAST <b>Ferriday</b>  |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |                      | 16b. SOCIAL SECURITY NO. <b>Unknown</b>  |  | 17. INFORMANT <b>Margaret F. Latrobe, Mother. Same as item 13</b>  |   |   |  | ADDRESS <b>13</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Injuries. Severe.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Trauma - Motor Cycle - Accident.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |                      |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |                      |  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY HOUR <b>12:00</b> A.M. MONTH <b>5</b> DAY <b>25</b> YEAR <b>1980</b>                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fall off motorcycle.</b>  |   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>  |  | 21f. LOCATION STREET <b>Wilson Lane</b> CITY OR TOWN <b>Bradley Blv.</b> COUNTY <b>Bethesda</b> STATE <b>Mont.</b>                                       |   |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                      |  |  |  |   |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>  |                      | TITLE (SPECIFY) <b>Deputy</b>  |  | MEDICAL EXAMINER   |   |   |  | DATE SIGNED <b>May 25, 1980</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>   |                      | ADDRESS <b>7936 Old Georgetown Rd., Beth., M.D.</b>  |  |  |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                      | 23b. DATE <b>5/28/1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>  |   | 23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b> COUNTY <b></b> STATE <b></b> |  |   |  |  |  |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>  |                      |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>JUN 2 1980</b>                                 |  | 25b. REGISTRAR'S SIGNATURE <b>L. K. K. K.</b>                                     |  |  |  |

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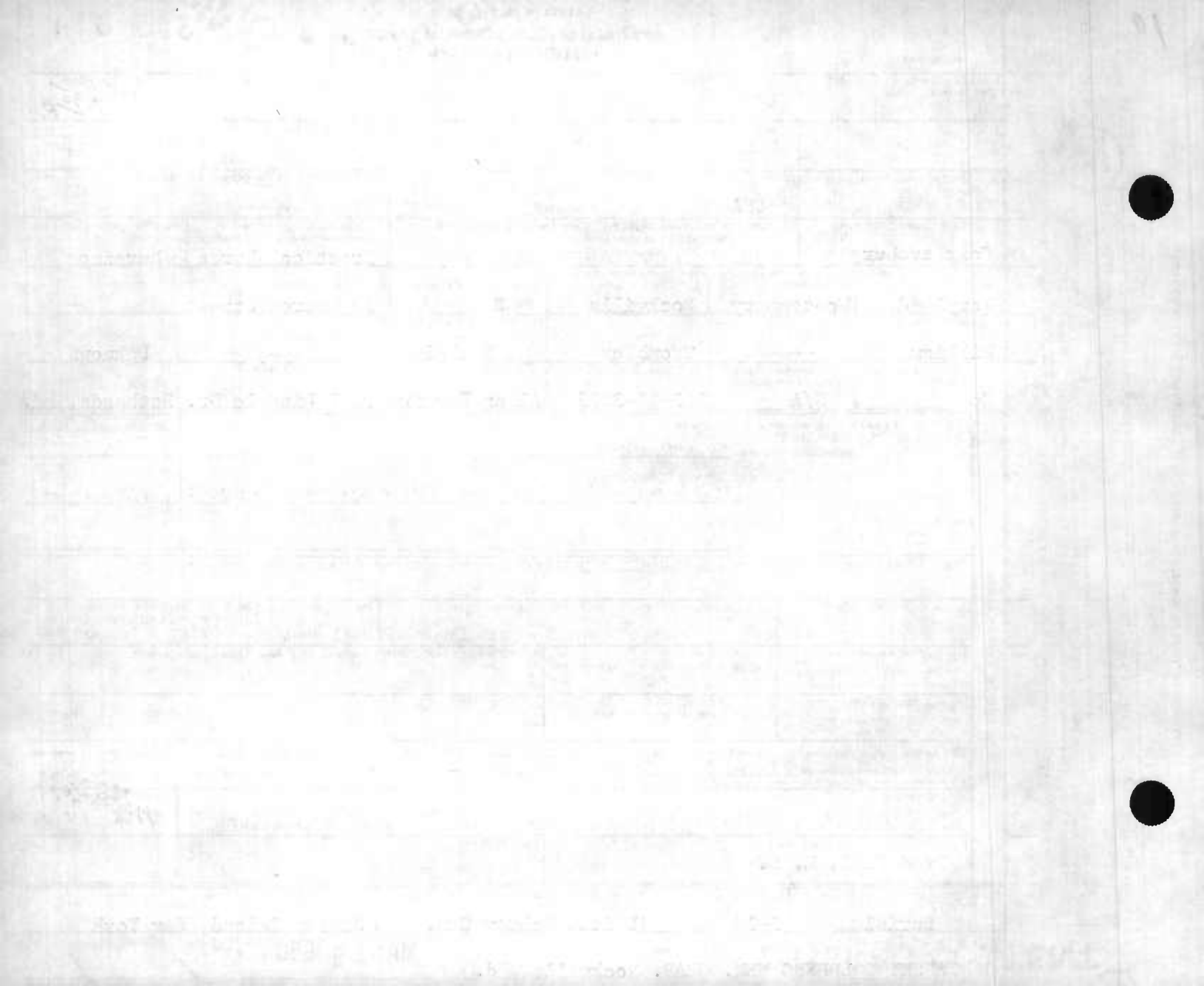


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Final may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |  |  |  |  | REG. NO.                          |  |
|---|--|---|--|---|---|--|--|--|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |   |  |  |  |  |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ada Raskin   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 14, 1980  |  |  | 2b. HOUR<br>7:35 P.M.  |  |                                   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 15, 1904  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>England  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA's   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |  |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Shady Grove Adventist |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Practical Nurse     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Nursing   |  |                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13b. STREET ADDRESS<br>90 Monroe Street                            |  |  |                                   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Rockville  |   |  |  |  |  |                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William ----- Trombler   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rachel ----- Unknown                              |  |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>N/A   |  | 17. INFORMANT<br>Allen Raskin, 9207 Lindale Dr. Bethesda, Md.   |   |  |  |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>years -</u><br>Approximate interval between onset and death: <u>3 weeks</u> |  |   |  |   |   |  |  |  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |  |  |  |  |                                   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 12, 1980</u> to <u>May 14, 1980</u> , that (I) (we) lost the deceased alive on <u>May 12, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |  |  |  |                                   |  |
| 22b. SIGNATURE<br><u>Fred Gill, M.D.</u>  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>May 15, 1980   |  |  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Fred Gill, M. D.   |  |   | 22e. ADDRESS<br>4743 Bradley Blvd.   |   |   |  |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>5-16-80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>United Hebrew Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Staten Island, New York |  |  |                                   |  |
| 24. FUNERAL DIRECTOR NAME<br>DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.   |  |   | ADDRESS  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 19 1980   |  | 25b. REGISTRAR'S SIGNATURE   |  |                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |   |  |  |   |   |
|--|--|---|---|--|---|--|--|---|---|
| 1- FOR STATE REGISTRAR   |  |   |   |  | REG. NO.  |  |  |   |   |
| 1 DECEASED NAME (TYPE OR PRINT) <u>Elsie H. Read</u>   |  |   |   |  | 2a DATE OF DEATH MONTH <u>5</u> DAY <u>15</u> YEAR <u>80</u>                                |  |  | 2b HOUR <u>9:15 P.M.</u>  |   |
| 3 SEX <u>Female</u>  |  | 4 RACE <u>white</u>   |   | 5 DATE OF BIRTH MONTH <u>9</u> DAY <u>06</u> YEAR <u>89</u>  |   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <u>90</u> YRS                     |   | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Wash DC</u>  |  | 7b CITIZEN OF WHAT COUNTRY? <u>US</u>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County MD.</u> |   |   |
| 10 CITY OR TOWN OF DEATH <u>Silver Spring</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u> |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>               |  |  | 12b KIND OF BUSINESS OR INDUSTRY <u>own home</u>  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <u>Maryland</u> 13b COUNTY <u>Montgomery</u> 13c CITY OR TOWN <u>Sil. Spring</u>  |  |   |   |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS <u>2101 Parker Avenue,</u>                    |   |   |
| 14 FATHER'S NAME FIRST <u>Francis</u> MIDDLE <u>P.</u> LAST <u>Holmes</u>  |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Isabele</u> MIDDLE <u></u> LAST <u>Kelser</u>             |  |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>   |  | 16b SOCIAL SECURITY NO. <u>220-48-8501</u>  |   | 17 INFORMANT (son) ADDRESS <u>Francis G. Read-(same as 13e)</u>  |   |  |  |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Coronary heart failure</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>arteriosclerotic cardiovascular disease with</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>diverse renal disease</u><br>(c) <u></u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5d.</u> |  |   |   |  |   |  |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>   |  |   |   |  |   |  |  |   |   |
| 19a DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>         |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |   |
| 22a I certify that (I) (this hospital) attended the deceased from <u>5/11/80</u> to <u>5/15</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5/15</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |  |  |   |   |
| 22b SIGNATURE <u>B.N. Rosenbaum, M.D.</u> DEGREE <u>M.D.</u>   |  |   |   |  |   | 22c. DATE SIGNED <u>5/16/80</u>  |  |   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>B.N. ROSENBAUM</u>   |  |   |   |  |   | 22e ADDRESS <u>3720 FARRAGUT AVE. KENSINGTON, MD 20795</u>                       |  |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  |   | 23b DATE <u>May 19, 1980</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery, Suitland Pk., Georges Md</u>     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                          |   |   |
| 24 FUNERAL DIRECTOR NAME <u>Warner E. Pumphrey, Inc.,</u> ADDRESS <u>8434 Ga. Ave.</u>   |  |   |   |  |   |  |  |   |   |

THE UNIVERSITY OF CHICAGO  
LIBRARY

Chicago, Ill.  
May 10, 1900  
Dear Sir,  
I have the pleasure to acknowledge the receipt of your letter of the 5th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,  
J. H. Thompson

J. H. Thompson  
The University of Chicago  
Chicago, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                                     |  | 8 0 1 3 3 8 6   |  |   |  |  |  |
|---|--|--|--|---|--|-------------------------------------|--|---|--|---|--|--|--|
| 1- REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |                                     |  | REG. NO.  |  |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |  |  | FIRST MIDDLE LAST   |  |                                     |  | 2a DATE OF DEATH MONTH DAY YEAR   |  |   |  | 2b HOUR                                      |  |
| Charles E. Reed   |  |  |  |   |  |                                     |  | 5-11-80   |  |   |  | 9:10 AM                                      |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  |                                     |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | 7a UNDER 1 YEAR   |  | 7b UNDER 24 HRS                              |  |
| MALE  |  | WHITE  |  | APRIL 30, 1890  |  |                                     |  | 90 YRS  |  | MONTHS DAYS   |  | HOURS MIN                                    |  |
| 7c BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7d CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |   |  | MD.  |  |
| 72 OHIO   |  | U.S.A.   |  |   |  | Montgomery                          |  |   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |                                     |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |
| 68 Silver Spring  |  | Holy Cross Hospital  |  |   |  |                                     |  |   |  | U.S. GOVERNMENT   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13a STATE   |  |                                     |  | 13b COUNTY  |  | 13c CITY OR TOWN  |  | 13d INSIDE CITY LIMITS?                      |  |
|   |  |  |  | MARYLAND  |  | MONTGOMERY                          |  | SILVER SPRING   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS                           |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |                                     |  |   |  |   |  |  |  |
| JACOB HENRY REED  |  |  |  | IDA MAE ARABRIGHT   |  |                                     |  |   |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT  |  | ADDRESS                             |  |   |  |   |  |  |  |
| YES   |  | WW I   |  | 579-32-0806   |  | MARY C. REED                        |  | SAME AS 13  |  | WIFE  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.  |  |  |  |   |  |                                     |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Cerebral ischemia   |  |  |  |   |  |                                     |  |   |  |   |  |  |  |
| 4370 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis   |  |  |  |   |  |                                     |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |                                     |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |                                     |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |                                     |  |   |  |   |  |  |  |
| 19a DATE OF OPERATION   |  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                     |  | 20a AUTOPSY?  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?       |  |  |  |
|   |  |  |  |   |  |                                     |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                                     |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
|   |  |  |  | P.M. 19   |  |                                     |  |   |  |   |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |                                     |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |
|   |  |  |  |   |  |                                     |  |   |  |   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 3-25-80 to May 11, 1980, that (I) (we) saw the deceased alive on May 10, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |                                     |  |   |  |   |  |  |  |
| 22b SIGNATURE   |  |  |  | DEGREE  |  |                                     |  | 22c DATE SIGNED   |  |   |  |  |  |
| Edward J. Richards  |  |  |  | MD  |  |                                     |  | 5-11-80   |  |   |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e ADDRESS   |  |                                     |  |   |  |   |  |  |  |
| EDWARD J. RICHARDS  |  |  |  | 10301 GEORGIA AVE., SILVER SPRING, MARYLAND   |  |                                     |  |   |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d LOCATION CITY OR TOWN COUNTY STATE                              |  |  |  |
| burial  |  |  |  | 5/14/80   |  | GATE OF HEAVEN                      |  |   |  | SILVER SPRING MONT MD.  |  |  |  |
| 24 FUNERAL DIRECTOR   |  |  |  | 25a DATE REC'D. BY REGISTRAR  |  |                                     |  | 25b REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| FRANCIS J. COLLINS  |  |  |  | MAY 15 1980   |  |                                     |  | Anthony McCreedy  |  |   |  |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  |   |  |                                     |  |   |  |   |  |  |  |

500 WIV. BLVD., SILVER SPRING, MD. 20901

FRANCIS J. COLLIER

GATE OF HEAVEN

SILVER SPRING

MD.

EDWARD J. RICHARDS

10301 GEORGIA AVE., SILVER SPRING, MARYLAND

YES

WM 1

570-20-0806

MARY C. REED

SAME AS 12

WIFE

JACOB

HENRY

REED

IDA

WIFE

APARTMENT

MARYLAND

MONTGOMERY SILVER SPRING X

12210 CINCINNATI ROAD DRIVE

CHILD

U.S.A.

WHITE

APRIL 30, 1960

20

WIFE

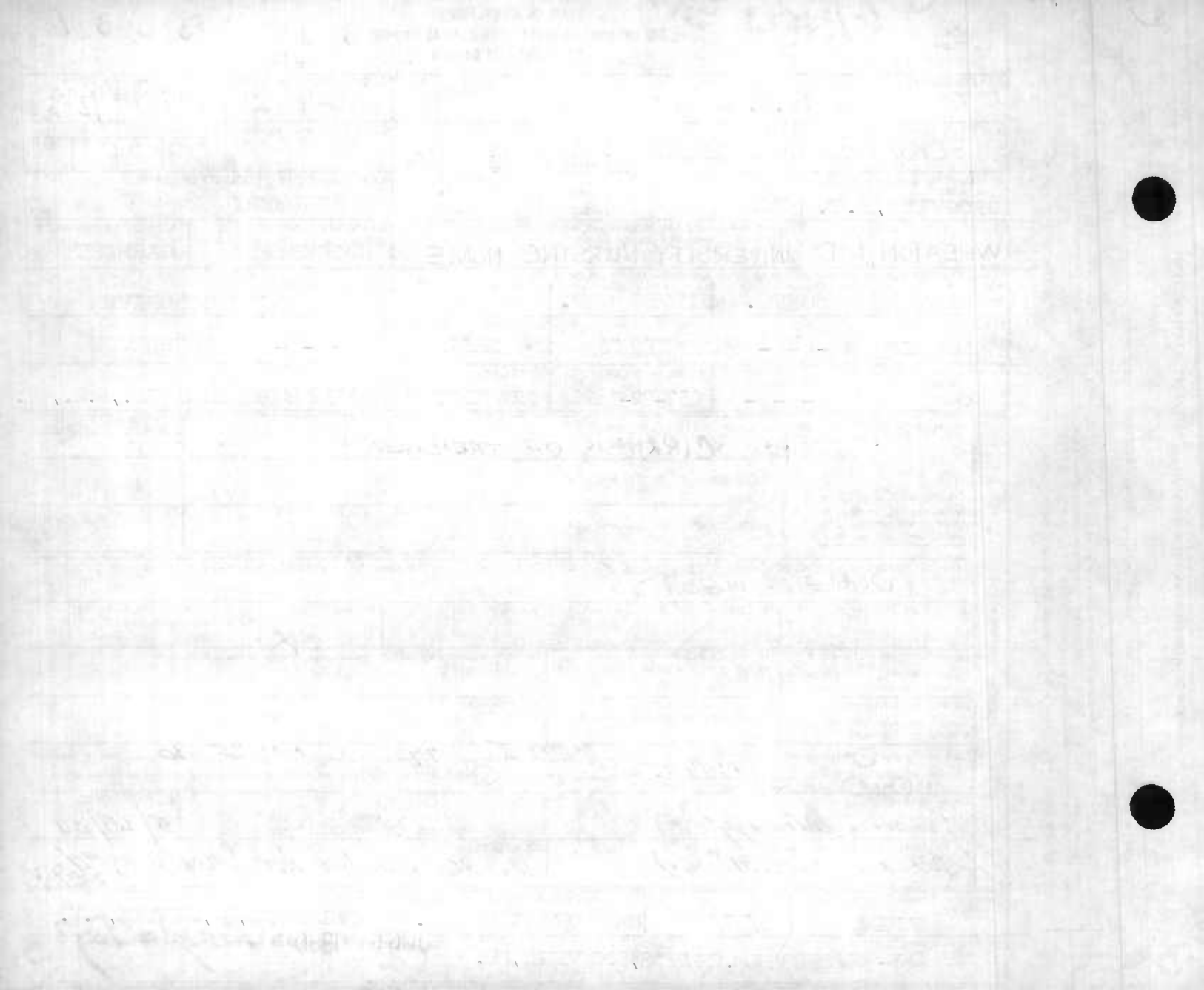


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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |   |  | REG. NO.  |  |  |
|---|--|--|--|---|--|--|--|---|--|---|--|--|
| 1 - STATE REGISTRAR   |  |  |  |   |  |  |  |   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) RAE K. (a.k.a. RACHEL) RICHARD  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 25, 1980  |  |  | 2b. HOUR<br>12 <sup>30</sup> A.M.   |  |   |  |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 16 1908  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BROOKLYN, N.Y.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                               |  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>WHEATON, MD.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY NURSING HOME |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BOOKKEEPER       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>GARMENT  |  |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY MONTG. 13c. CITY OR TOWN SILVER SPR.   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>11641 LOCKWOOD DRIVE                                |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MORRIS - - - KARNEFSKY  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH - - - RACHELSON   |  |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>057-22-1626  |  | 17. INFORMANT ADDRESS<br>MARK RICHARD (SON) 912 BURNT CREST LA., S.S., MD. |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) CIRRHOSIS OF THE LIVER<br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>DIABETES MELLITUS |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 15 1979 to MAY 25 1980, that (I) (we) last saw the deceased alive on MAY 25 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br>JEROME SCHWAPP MD   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   |  | 22c. DATE SIGNED<br>5/25/80                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JEROME SCHWAPP MD  |  |  |  |   | 22e. ADDRESS<br>11161 New Hampshire Ave Shadyspring MD 20794   |  |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>5/27/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW MONTEFIORE CEM.  |  |  | 23d. LOCATION<br>FARMINGDALE, LI, SUFFOLK, N.Y.   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>DANZANSKY-GOLDBERG MEM. CHAPEL, ROCKVILLE, MD.  |  |  |  |   | 25. JUDICIAL DISTRICT CLERK<br>JUN 3 1980  |  | 26. REGISTRAR'S SIGNATURE  |   |  |   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |   |   |
|---|--|---|--|---|---|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   | REG. NO.  |   |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LEONA V. RISLEY</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAY 13, 1980</b>   |   |  |   | 2b. HOUR<br><b>1:30p</b> M  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 25, 1894</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                               |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Kensington</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Circle Manor Nursing Home</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Sales Clerk</b> |  | 12b. KIND OF BUSINESS OR<br><b>Lanaburghs Dept Store</b>  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Prince Geo.</b> 13c. CITY OR TOWN <b>E. Riverdale</b>   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |   | 13e. STREET ADDRESS<br><b>6112 Longfellow Street</b> |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALOYSIUS LANGLEY</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY RILEY</b>  |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>577 01 6776A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Harry A. Hetzler Same as #13 (Son)</b>   |   |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Atherosclerotic heart disease</b><br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST.<br><b>4140</b> |  |   |  |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>instant</b><br><b>years</b><br><b>years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12/28 78</b><br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3720 FARRAGUT AVE.<br/>KENSINGTON MD - 20795</b>  |   |   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/12 80</b> to <b>5/13 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or we) did (did not) view the body after death.  |  |   |  |   |   |   |  |   | 22c. DATE SIGNED<br><b>5/13/80</b>  |
| 22b. SIGNATURE<br><b>Martin C. Shargel D</b>  |  |   |  |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN C. SHARGEL</b>   |  |   |  |   | 22e. ADDRESS<br><b>3720 FARRAGUT AVE.<br/>KENSINGTON MD - 20795</b>   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/16/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Md.</b>                     |  |   |   |
| 24. FUNERAL DIRECTOR<br><b>Francis Gasch's Sons Funeral Home, P.A.</b><br><b>Hyattsville, Maryland</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 16 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 3 8 9

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |   |  |   |  |  |
|---|--|--|---|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elsia Marie Rithman</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 20, 1980</b>              |   |  | 2b. HOUR<br><b>7:30am</b>  |   |  |   |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 21, 1943</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>36</b> YRS   |   | # UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>      |   | # UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD</b>                        |   |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Clinical Center, NIH</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Prince Geo.</b>                                       |   | 13c. CITY OR TOWN<br><b>Landover</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6605 W. Forest Rd. 20785</b>  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernest C. Boswell</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsia E. Penwell</b> |   |  |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>Unknown</b>                              |   | 17 INFORMANT<br><b>John Rithman</b>  |  |   | ADDRESS<br><b>(same)</b>                         |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypercalcemia</b><br><b>2028</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Lymphoma (diffuse undifferentiated)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>5 year</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b></b>  |  |  |   |   |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>       |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 18, 1980</b> to <b>May 20, 1980</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 20, 1980</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. |  |  |   |   |  |  |   |  |   |  |  |
| 22a. SIGNATURE<br><b>B. Foster M.D.</b>   |  |  |   |   |  | DEGREE   |   | 22b. DATE SIGNED<br><b>5/20/80</b>               |   |  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRENDA FOSTER</b>   |  |  |   |   |  | 22d. ADDRESS<br><b>Clinical Center, National Institutes of Health, Bethesda, Md. 20205</b> |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>May 22, 1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale</b>                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Martinsburg, W.Va.</b>                         |  |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Capitol Funeral Service</b><br><b>Fairfax, Va.</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 1 3 3 9 0  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1- FOR STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH   |  |   |   |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH  |  |   |   |
| FIRST MIDDLE LAST<br>William T Rock   |  |   |  | MONTH DAY YEAR<br>5 6 80   |  |   |   |
| 3 SEX<br>Male   |  | 4 RACE<br>Caucasian   |  | 5 DATE OF BIRTH  |  | 2b. HOUR<br>140 P.M.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Bridgetown, Conn.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>94   |  | 8 IF UNDER 1 YEAR<br>MONTHS DAYS  |   |
| 10 CITY OR TOWN OF DEATH<br>Rockville, Md   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Collinswood Nursing Center |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery, MD.                               |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Elec. Cont. Electrical   |   |
| 13a. STATE<br>MD  |  |   |  | 13b. COUNTY<br>Montg.  |  | 13c. CITY OR TOWN<br>Rockville  |   |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |
| FIRST MIDDLE LAST<br>Patrick Rock   |  |   |  | FIRST MIDDLE LAST<br>Bma Carey   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, 'UNKNOWN')<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>049-05-4069A   |  | 17. ADDRESS<br>ANNE VINER 14701 WESTBURY RD., ROCKVILLE, MD.  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardiac arrhythmia<br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) Myocardial ischemia w/ electrolyte imbalance<br>(c) Arteriosclerotic heart disease + decompensation<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Arteriosclerotic cerebrovascular disease |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Minutes<br>Hours<br>Years |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |   |
| 22a. I certify that (I) (the hospital) attended the deceased from February 19 80, to 5/6 19 80, that (I) (we) lost saw the deceased alive on 5/2 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |   |
| 22b. SIGNATURE<br>Thomas J. Garvey M.D.   |  |   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>5/6/80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THOMAS J. GARVEY JR., M.D.   |  |   |  | 22e. ADDRESS<br>50 W. Edmonston Dr., Rockville, Md.                                  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>5-8-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN CEMETERY                        |  | 23d. LOCATION<br>SILVER SPRING MONTG. MD.   |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES P/A   |  |   |  | ADDRESS<br>ROCKVILLE MD.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 12 1980  |   |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>T. J. Garvey   |  |   |   |



ANNE ALLEN JAVOZ WESTBURY RD. ROCKVILLE

ROBERT A. PURNBERY FUNERAL HOMES 118 MAY 1961  
GATE OF HEAVEN CEMETERY 118 MAY 1961  
BRIAL 2-8-60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  |  |  |  |  |   |  |
| REG. NO. 8013391   |  |   |  |  |  |  |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Agnes Lofald Rodenbur   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>5 24- 80 |  |  | 2b HOUR<br>1:20 P.M.   |  |   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>W   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>3 17 94   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS   |  | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE (COUNTRY)<br>MINNESOTA   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Gaithersburg, Md.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Herman Wilson Health Care Center |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher & Secty   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Education - Gov.  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |  |  |   |  |
| 13a STATE<br>Md.   |  | 13b COUNTY<br>Montgomery  |  | 13c CITY OR TOWN<br>Takoma Park  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael - Lofald  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Natalie - HAGESTAD   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No   |  |  |  |   |  |
| 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>474-03-4136  |  | 17 INFORMANT<br>Records ADDRESS 301 Russell Ave.,<br>Wilson Health Care Center Gaithersburg, Md.  |  |  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis &amp; Hypertensive Cardiac</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Vascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anemia</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 YRS<br>2 YRS |  |   |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  |  |   |  |
| MEDICAL CERTIFICATION  |  |   |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a I certify that (I) (the hospital) attended the deceased from <u>1974</u> , 19 <u>80</u> , to <u>May 24</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5/21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |   |  |  |  |  |  |   |  |
| 22b SIGNATURE<br><u>Lawrence J. Thomas M.D.</u>  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br>5/25/80  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lawrence J. Thomas, M.D.   |  |   |  | 22e ADDRESS<br>11801 Rockville Pike<br>Rockville, Md. 20852  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b DATE<br>5/25/80   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C.  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME <u>Marshall Sandison</u><br>Gartner-Sandison F. H.   |  |   |  | 316 E. Diamond Ave.<br>Gaithersburg, Md.   |  | 25 DATE REG'D BY REGISTRAR<br>MAY 26 1980  |  | 25b REGISTRAR'S SIGNATURE<br><u>Gregory Melindy</u>   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE **8 0 1 3 3 9 2**  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |   |   |  |
|--|--|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>James Jefferson Rogers</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 31, 1980</b>                              |   |  | 2b. HOUR<br>PM<br><b>12:45</b>   |   |   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 01 1927</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b>   |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Clinical Center, NIH</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DRIVER</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DELIVERY</b>  |  |
| 13a. STATE<br><b>Virginia</b>  |  |  | 13b. COUNTY<br><b>SHENANDOAH</b>  |   | 13c. CITY OR TOWN<br><b>Woodstock</b>                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES J. ROGERS</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HENRIETTA CARROLL</b>               |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES<br><b>YES WWII</b> |   |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>149-20-8264</b>   |  |  | 17. INFORMANT<br>ADDRESS<br><b>Elsie Rogers, wife, same AS #13</b>                      |   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Abdomen-perforation of bowel</b><br><br>2030 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Progressive nodular poorly differentiated lymphoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                              |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>28 May 19 80</b> , to <b>31 May 19 80</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>31 May 19 80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) did not see the body after death. |  |  |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i> MD  |  |  | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>June 1, 1980</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MAX WKHA, M.D.</b>   |  |  | 22e. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda, Md</b> |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>6-4-1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SUNSET VIEW MEM. GRD.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WOODSTOCK, SHENANDOAH, VA.</b>                 |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W. W. CHAMBERS CO.</b>  |  |  | ADDRESS<br><b>RIVERDALE, Md.</b>  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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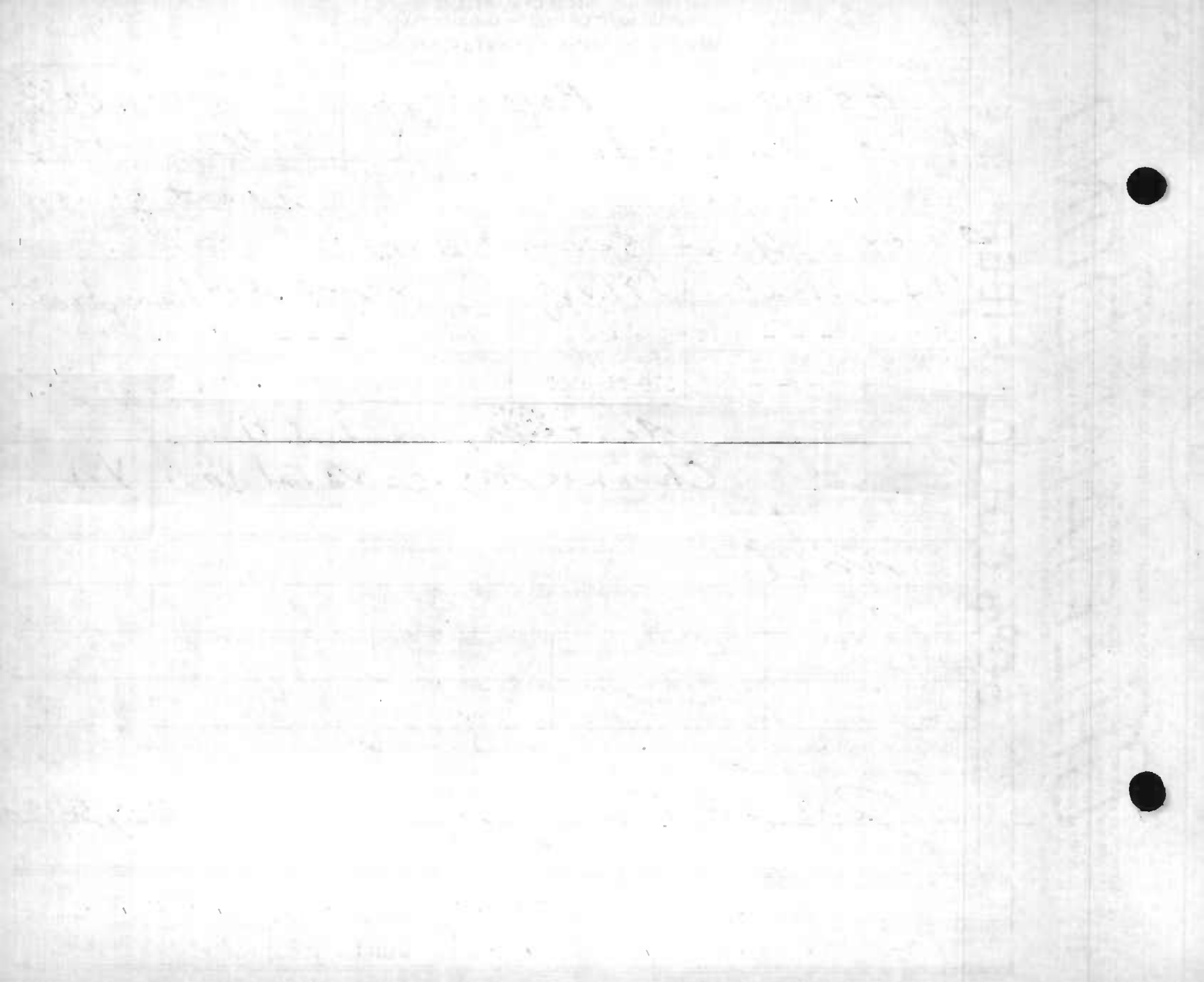
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE<br>REGISTRAR   |  |                  |  |   |  |  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |                      |  |   |  |  |  | REG. NO. 13393  |  |                                |  |  |  |  |  |  |  |   |  |  |  |
|--|--|------------------|--|---|--|--|--|---|--|--|--|---|--|----------------------|--|---|--|--|--|---|--|--------------------------------|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Henry Rosenberg</i>   |  |                  |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH MATED <i>May 31, 1980</i>                                  |  |   |  |                      |  |   |  |  |  | 2b. DATE OF ESTI. MATED <i>May 31, 1980</i>                                 |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| 3. SEX <i>M</i>  |  | 4. RACE <i>W</i> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>Nov 21 14 66</i>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN. <i>14 YRS.</i> |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD <i>May 31, 1980</i>  |  | 7d. HOUR <i>9:50</i> |  | 7e. MIN. <i>50</i>                        |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>BALTIMORE, MD.</i>   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i>                           |  |                      |  | 10. CITY OR TOWN OF DEATH<br><i>Olney</i> |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Olney</i>  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mont. General Hospital</i> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>KITCHEN DESIGN</i>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>RES. CONSTR.</i>                            |  |                      |  |   |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                  |  |   |  |  |  |   |  | 13a. STATE <i>MD</i>   |  |   |  |                      |  |   |  |  |  | 13b. COUNTY <i>Mont.</i>  |  | 13c. CITY OR TOWN <i>Olney</i> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>248 Northampton Dr</i> |  |  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>JACOB - - - ROSENBERG</i>   |  |                  |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>ANNA - - - LEVY</i>            |  |   |  |                      |  |   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO, OR UNKNOWN) <i>NO</i> |  |                                |  | 16b. SOCIAL SECURITY NO.<br><i>579-24-0193</i>   |  | 17. INFORMANT<br><i>ELLA ROSENBERG (WIFE)</i>    |  |  |  | ADDRESS<br><i>SILVER SPRING, MD. 748 NORTHAMPTON DR.,</i> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><i>4291</i><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                  |  |   |  |  |  |   |  | (a) <i>Acute Myocardial Infarction</i>   |  |   |  |                      |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |                                |  |  |  |  |  |  |  |   |  |  |  |
|  |  |                  |  |   |  |  |  |   |  | (b) <i>Chronic Myocardial Infarction</i>   |  |   |  |                      |  |   |  |  |  | <i>Yrs</i>  |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |   |  |  |  |   |  | <i>None</i>  |  |   |  |                      |  |   |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
|  |  |                  |  |   |  |  |  |   |  |  |  |   |  |                      |  |   |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><i>None</i>  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                      |  |   |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |                      |  |   |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                      |  |   |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |  |  |   |  |                      |  |   |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>[Signature]</i>   |  |                  |  | TITLE (SPECIFY)<br><i>M.D.</i>  |  |  |  | MEDICAL EXAMINER<br><i>[Signature]</i>  |  |  |  | DATE SIGNED<br><i>May 31, 1980</i>  |  |                      |  |   |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                  |  | ADDRESS   |  |  |  |   |  |  |  |   |  |                      |  |   |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  |                  |  | 23b. DATE<br><i>6/2/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>KING DAVID MEM. GARDEN</i>      |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>FALLS CHURCH, FAIRFAX, VA.</i>    |  |   |  |                      |  |   |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>DANZANSKY-GOLDBERG MEM. CHAPELS, ROCKVILLE, MD.</i>   |  |                  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 5 1980</i>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |   |  |                      |  |   |  |  |  |   |  |                                |  |  |  |  |  |  |  |   |  |  |  |



## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John W. Rosenberger</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>05 08 80</b>  |  | 2b. HOUR<br><b>6:55AM</b>   |   |
| 3 SEX<br><b>male</b>   |  | 4 RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 27 1883</b>  |   |
| 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>97</b>  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b>  |  | MD.   |   |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery Gen. Hosp.,</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired Methodist Minister</b> |   |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STREET ADDRESS<br><b>1503 Viers Mill Road</b>  |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William H. Rosenberger</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lelia R. Frye</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                     |   |
| 16b. SOCIAL SECURITY NO<br><b>220 44 7875</b>  |  | 17 INFORMANT<br><b>Dr. Gordon Rosenberger</b>   |  | ADDRESS <b>310 W. Montgomery Ave</b>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial failure</b><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD + acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes mellitus</b> |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>4 hrs.</b><br><b>2 wks.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                     |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>4-25-80</b> 19____, to <b>5-8-80</b> 19____, that (I) <del>lost</del> saw the deceased alive on <b>5-8-80</b> 19____, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did not</del> view the body after death. |  | 22b. SIGNATURE<br><b>Frederick Moomau, MD,</b>  |   |
| 22c. DATE SIGNED<br><b>5-8-80</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frederick Moomau</b>  |  | 22e. ADDRESS<br><b>1811 Prince Philip Dr. Olney, Maryland</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5/10/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rockville Union Cemetery</b>                                 |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Maryland</b>   |  | 24 FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home, Inc.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 13 1980</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>John B. B...</b>  |  | 25c. ADDRESS<br><b>1331 Rockville Pike Rockville, Maryland</b>  |  | 25d. DATE REC'D. BY REGISTRAR<br><b>MAY 13 1980</b>   |   |

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THE MEDICAL EXAMINER MUST BE NOTIFIED OF DEATH.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |                               |  |   |   |  |   |               | REG. NO. 13395  |  |               |
|--|-------------------------|--|-------------------------------|--|---|---|--|---|---------------|---|--|---------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>FANNY ROSENFELD</b>  |                         |  |                               |  |   |   |  |   |               | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>May 29 1980</b>                     |  | 7b. HOUR<br>M |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUGUST 23, 1900</b>   |                               | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>79 YRS.</b>                       | IF UNDER 1 YR<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>May 29 1980</b> |   | 2d. HOUR<br>M |   |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GERMANY</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.    |   |               |   |  |               |
| 10. CITY OR TOWN OF DEATH<br><b>Sil. Spg.</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8484 16th St.</b> |                               |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |               |   |  |               |
| 13a. STATE<br><b>MD</b>  |                         | 13b. COUNTY<br><b>Mont</b>   |                               | 13c. CITY OR TOWN<br><b>Sil. Spg</b>                                       |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>16th St. Apt. 510</b>   |               |   |  |               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>KALMAN STRAUSS</b>  |                         |  |                               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>REGINA MAYER</b>  |   |  |   |               |   |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO, OR UNKNOWN)<br><b>NO</b>  |                         |  |                               | 16b. SOCIAL SECURITY NO.<br><b>577-34-2277</b>                             |   | 17. INFORMANT<br>ADDRESS<br><b>HERMAN ROSENFELD, 11572 BEDFORDSHIRE AVENUE, POTOMAC, MARYLAND</b> |  |   |               |   |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9570 IMMEDIATE CAUSE (a) Multiple Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Fall from balcony</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                         |  |                               |  |   |   |  |   |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |                               |  |   |   |  |   |               |   |  |               |
| 19a. DATE OF OPERATION<br><b>None</b>  |                         |  |                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                          |   |   |  |   |               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |               |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>6:20 P.M. 5 29 1980</b>   |                         |  |                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5 29 1980</b>        |   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Jumped from 5th Floor balcony</b> |               |   |  |               |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |                         |  |                               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b> |   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>8484 16th St. Sil. Spg. Mont. MD</b>                          |               |   |  |               |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |                               |  |   |   |  |   |               |   |  |               |
| ACTUAL SIGNATURE<br><b>DR. JOHN S. ROGERS</b>  |                         |  |                               | TITLE (SPECIFY)<br><b>DR.</b>  |   |   |  | MEDICAL EXAMINER<br><b>1919 SEMINARY ROAD, SILVER SPRING, MARYLAND</b>  |               |   |  |               |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>DR. JOHN S. ROGERS, M.D.</b>   |                         |  |                               | ADDRESS<br><b>1919 SEMINARY ROAD, SILVER SPRING, MARYLAND</b>              |   |   |  | DATE SIGNED<br><b>May 29, 1980</b>  |               |   |  |               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |                         |  | 23b. DATE<br><b>5/30/1980</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT LEBANON CEMETERY</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ADELPHI PRINCE GEORGES MD.</b>                                       |               |   |  |               |
| 24. FUNERAL HOME<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>  |                         |  |                               |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 3 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |               |   |  |               |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C.   |                         |  |                               |  |   |   |  |   |               |   |  |               |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   | REG NO.  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) <b>Edith</b>  |  |   |  |   | 2a DATE OF DEATH MONTH DAY YEAR <b>5/6/80</b>                                |  |  |  |  |
| 3 SEX <b>Female</b>   |  |   |  |   | 2b HOUR <b>10:30 P.M.</b>  |  |  |  |  |
| 4 RACE <b>Black</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>Aug. 9, 1920</b>  |  |   | 6 AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS                                 |  |  | IF UNDER 1 YEAR MONTHS DAYS  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>   |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH <b>Takoma Park</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b> |  |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b> |  |  | 12b KIND OF BUSINESS OR INDUSTRY <b>Char</b>   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b> 13b COUNTY <b>P.G.</b> 13c CITY OR TOWN <b>Brentwood</b> 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   | 13e STREET ADDRESS <b>4524 Rhode Island Ave.</b>                             |  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>Edward</b>  |  |   |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Hawkins</b>             |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)  |  |   |  |   | 16b SOCIAL SECURITY NO. <b>214-18-8435</b>                                   |  |  |  |  |
| 17 INFORMANT ADDRESS <b>Lorraine Franklin-4550 R.I.Ave.</b>   |  |   |  |   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Large cell Cancer of the lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)        |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>              |   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>Nov</b> 19 <b>79</b> to <b>May</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>5-6</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (add) (do not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b SIGNATURE <b>Kai-Yin Yeung, MD</b> DEGREE   |  |   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED <b>5-7-80</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kai-Yin Yeung, MD</b>   |  |   |  |   |  | 22e ADDRESS <b>6525 Belcrest Rd #460, Hyattsville MD 20784</b>   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |   | 23b DATE <b>5-10-80</b>  |   |  | 23c NAME OF CEMETERY OR CREMATORY <b>QUEENS CHAPEL CH. CFM.</b>  |  | 23d LOCATION CITY OR TOWN COUNTY STATE <b>MURKIRK P.G. MD.</b>   |  |
| 24 FUNERAL DIRECTOR NAME <b>H. S. WASHINGTON + SONS</b> ADDRESS <b>4925 BURROUGHS AVE N.E.</b>  |  |   |  |   |  | 25a DATE RECD. BY REGISTRAR <b>MAY 1 1980</b> 25b REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |  |  |

Female

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Nov. 9, 1920

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Ms.

U.S.A.

Montgomery

Alabama Park

Washington Adventist Hosp.

Domestic

Char

Ms.

I.C.

Brentwood

x

4524 Rhode Island Ave.

Edward

Hess

William

Hawkins

No

214-18-0435 Lawrence Franklin-4550 E. 1. Ave.

Partial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| 1. FOR<br>1- STATE<br>REGISTRAR  |  | 8 0 1 3 3 9 7   |  | REG. NO.   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARIE ROSS</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 30, 1980</b>   |  | 2b. HOUR<br><b>7 a.m.</b>  |  |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 31, 1900</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><b>00 00</b>       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Chevy Chase</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5500 Friendship Blvd.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Chevy Chase</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>5500 Friendship Blvd.</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gesvaldo Scarpelli</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Antoinette Labriola</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>091-14-3825</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>5500 Friendship Blvd,<br/>Frank Ross (Son) Chevy Chase, Maryland</b>   |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>3319<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Cerebral Atrophy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2 years</b> |  |   |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 18, 1979</b> to <b>May 30, 1980</b> , that (I) (we) last saw the deceased alive on <b>May 28, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Christopher Unger, M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>May 30, 1980</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Christopher Unger, M.D.</b>  |  | 22e. ADDRESS<br><b>8218 Wisc. Ave. Beth., Md.</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>June 2, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring Montgomery MD.</b>  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons, Inc.</b>   |  | ADDRESS<br><b>5130 Wisc. Ave. N.W. Wash., D.C.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 6 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey McBrady</b>   |  |   |  |

Nov 22, 1950

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January 21, 1951

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U. S. A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |   |   |  |
|---|--|---|--|---|---|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |   | REG. NO. 8013398   |   |   |   |   |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |   | 2a DATE OF DEATH   |   |   | 2b HOUR   |   |   |  |
| FIRST MIDDLE LAST<br>William L. Rush  |  |   | MONTH DAY YEAR<br>MAY 14 1980                                      |   |   | 2400 M  |   |   |  |
| 3 SEX   |  | 4 RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | 7. UNDER 1 YEAR   |  |
| Male  |  | Caucasian   |  | MONTH DAY YEAR<br>Dec. 7, 1895  |   | 94 YRS.   |   | # UNDER 24 HRS  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?                             |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |   |   |  |
| Missouri  |  | U S A   |  |   |   | Montgomery MD.  |   |   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  |   |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |   | 12b KIND OF BUSINESS OR INDUSTRY                              |  |
| Vbeaton   |  | University Nursing Home                                 |  |   |   | Repairman   |   | Appliance   |  |
| 13a STATE   |  |   | 13b COUNTY   |   | 13c CITY OR TOWN  |   | 13d INSIDE CITY LIMITS?   |   |  |
| Maryland  |  |   | Mont.  |   | Takoma Park   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14 FATHER'S NAME  |  |   | 15 MOTHER'S MAIDEN NAME  |   |   | 13e STREET ADDRESS  |   |   |  |
| FIRST MIDDLE LAST<br>Joseph Rush  |  |   | FIRST MIDDLE LAST<br>Saphronia Sandles                             |   |   | 7051 Carroll Ave., 20012  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   | 16b SOCIAL SECURITY NO   |   | 17 INFORMANT ADDRESS  |   |   |   |  |
| No  |  |   | 578-26-1558  |   | Maryland<br>Shirley Dean-35824 Raymond St., Chevy Chase,                      |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Recurrent Stroke</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Seizure Disorder</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |   |   |   |   |  |
| 19a DATE OF OPERATION   |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a AUTOPSY?  |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b TIME OF INJURY   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |  |
|   |  |   | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                |   |   |   |   |   |  |
| 21d INJURY OCCURRED   |  |   | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f LOCATION  |   | 21g CITY OR TOWN  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  |   | STREET  |   | COUNTY STATE  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>June 18</u> , 19 <u>80</u> , to <u>May 14</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4/20/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |   |  |   |   |   |   |   |  |
| 22b SIGNATURE   |  |   |  |   |   | DEGREE  |   | 22c DATE SIGNED   |  |
| <u>[Signature]</u>  |  |   |  |   |   |   |   |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   |   | 22e ADDRESS   |   |   |  |
| SMITH HO M.D  |  |   |  |   |   | 8323 HADDON DR TAKOMA PK MD   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   | 23b DATE   |   | 23c NAME OF CEMETERY OR CREMATORY   |   | 23d LOCATION  |   |  |
| Burial  |  |   | 5/17/80  |   | Cedar Hill  |   | CITY OR TOWN COUNTY STATE<br>Suitland, P. G. Co., Md.               |   |  |
| 24 FUNERAL DIRECTOR   |  |   |  |   |   | 25a DATE REC'D BY REGISTRAR   |   | 25b REGISTRAR'S SIGNATURE                                     |  |
| NAME ADDRESS<br>W. W. Chambers Co., Silver Spring, Maryland.  |  |   |  |   |   | MAY 21 1980   |   | <u>[Signature]</u>  |  |

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William  
May 1 1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8 0 1 3 3 9 9<br>REG. NO 0005340   |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| Shirlee Mae Rushing   |  |  |  |   |  |  |  | May 09 1980   |  | 1945 M                                       |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 IF UNDER 1 YEAR MONTHS DAYS   |  | 8 IF UNDER 24 HRS. HOURS MIN.                |  |
| Female  |  | Caucasian  |  | October 14 1932   |  | 47 YRS.  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| Illinois  |  | United States  |  |   |  | Montgomery County MD.  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  |   |  |  |  |
| Bethesda  |  | National Naval Medical Center  |  |   |  |  |  |   |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |   |  |  |  |
| House Wife  |  |  |  |   |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland  |  | Mont   |  | Damascus  |  |  |  | 10724 Middleboro Drive  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |  |  |  |   |  |  |  |
| Melvin Joseph Gerrard   |  | Billie Vada Boules   |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17 INFORMANT ADDRESS  |  |  |  |   |  |  |  |
| No  |  | 347-26-0222<br>355-16-4881   |  | Charles Rushing Captain USN (Ret.) SAA  |  |  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiop. Arrest</u>  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 1830 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Widely Metastatic Ovarian Cancer</u>   |  |  |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |  |  |
| Charles P. Coddington   |  | MD   |  |   |  |  |  | 10 May 1980   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |  |  |   |  |  |  |
| Charles E. Coddington   |  | National Naval Medical Center Bethesda, Md.  |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial  |  | May 13 1980  |  | Arlington National Cem.   |  | Arlington, Va.   |  |   |  |  |  |
| 24 FUNERAL DIRECTOR NAME  |  | 24b. DATE REC'D. BY REGISTRAR  |  | 24c. REGISTRAR'S SIGNATURE  |  |  |  |   |  |  |  |
| Murphy Funeral Home   |  | May 13 1980  |  | [Signature]   |  |  |  |   |  |  |  |
| Wilson Blvd. Arlington Va.  |  |  |  |   |  |  |  |   |  |  |  |

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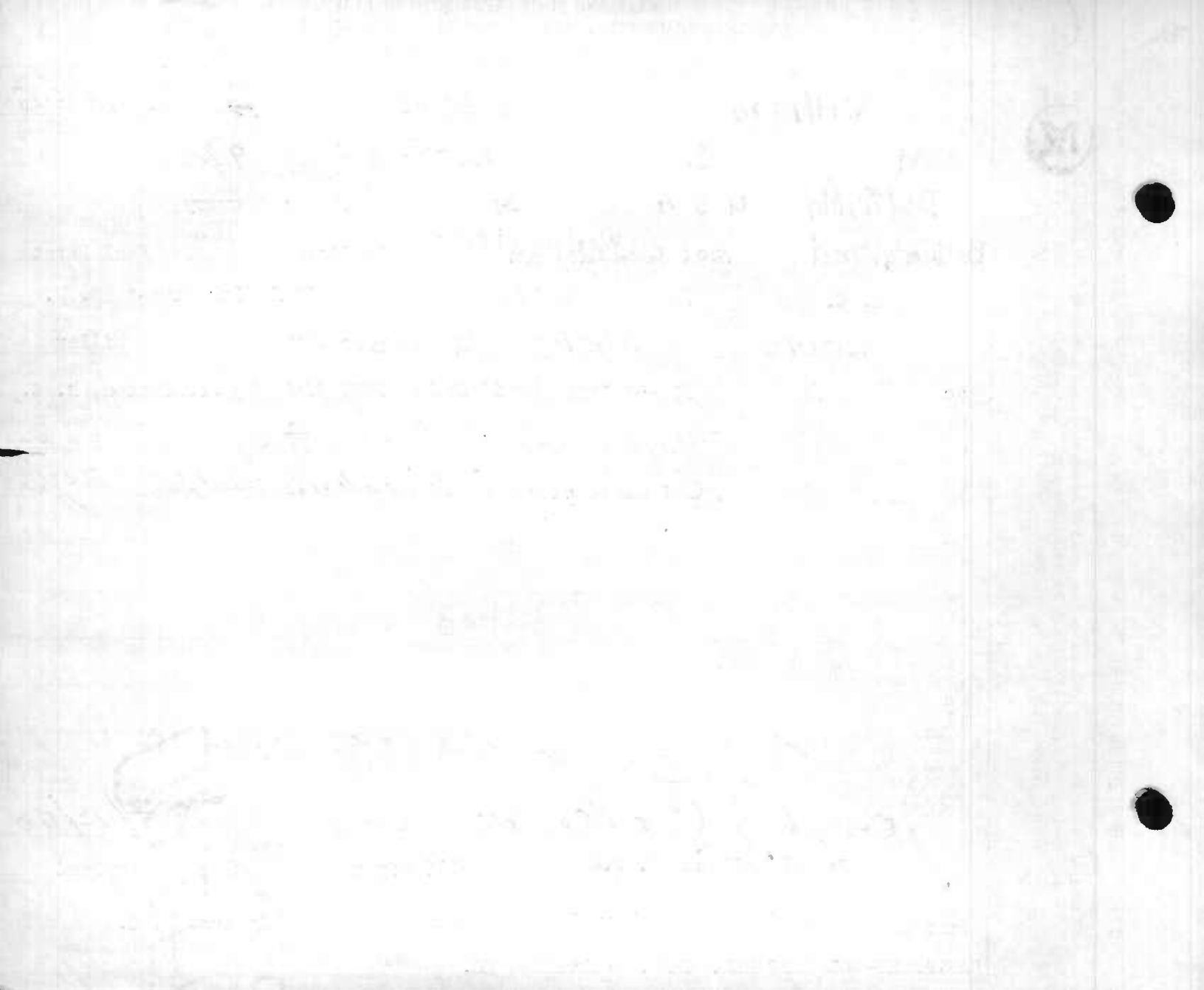
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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>William</b>   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month <b>5</b> Day <b>12</b> Year <b>80</b>  |  |  | 2b. HOUR<br><b>5:20</b> A   |  |  |
| 3. SEX<br><b>M</b>   |  |  | 4. RACE<br><b>C</b>  |  |  | 5. DATE OF BIRTH<br><b>12-5-88</b>  |  |  | 6. AGE (In years lost birthday)<br><b>92</b> YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balti, Md</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>1 Montgomery</b> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda, Md</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Westwood Rf. 5101 Ridgefield Rd</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Realtor</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>D. C.</b>  |  |  | 13b. COUNTY<br><b>N/A</b>  |  |  | 13c. CITY OR TOWN<br><b>Washington</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>3227 45th Street, N. W.</b>   |  |  | 14. FATHER'S NAME<br>First Middle Last<br><b>Louis SACHS</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Miller Sarah --- Miller</b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>N/A</b>  |  |  | 17. INFORMANT<br><b>David Sachs, 3227 45th NW, Washington, D. C.</b>  |  |  | Address   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary Atherosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 hr.</b><br><b>3 1/2 hr.</b> |  |  |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/3</b> , 19 <b>80</b> , to <b>5/12</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>5/11</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Joseph Wallace, M. D.</b>   |  |  |  |  |  | 22c. DATE SIGNED<br><b>5/12/80</b>  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Joseph Wallace, M. D.</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>5272 River Road, Bethesda, Maryland</b>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>5-14-80</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ohev Shalom Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D. C.</b>                       |  |  |
| 24. FUNERAL DIRECTOR<br><b>DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.</b>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>MAY 16 1980</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>   |  |  |



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IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |  |  |  |   | 8 0 1 3 4 0 1  |  |
|---|--|---|--|---|---|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |   |  |  |  |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Henrietta M Lalsburg</i>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>May 21 1980</i>            |  |  |  |   | 2b. HOUR<br><i>6:40 PM</i>   |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>white</i>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><i>7 5 86</i>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>93</i> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |   | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Ohio</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Rockville</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Collingswood Nursing Center</i> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>                                     |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Md.</i>   |  |   |  |   | 13b. COUNTY<br><i>Montg.</i>                                      |  | 13c. CITY OR TOWN<br><i>Rockville</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>John Malone</i>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Mary Kearney</i> |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><i>264-78-1807</i>                    |  | 17. INFLUENT ADDRESS<br><i>Virginia S. Bill 2228 Demington Dr., Cleveland Heights Ohio</i> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Cardiac arrest</i><br><i>4280</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Congestive Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>immediate</i><br><i>2-3 days</i>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><i>—</i>  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>—</i>  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i>—</i>   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>—</i>   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><i>—</i>   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>23 Feb</i> , 19 <i>78</i> , to <i>21 May</i> , 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>7 May</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |   |  |   |   |  |  |  |   |  |  |
| 22b. SIGNATURE<br><i>John D. Gurswald MD</i>  |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>21 May 1980</i>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>John D. Gurswald MD</i>   |  |   |  |   |   | 22e. ADDRESS<br><i>4830 V St NW, Washington, DC</i>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Cremation</i>   |  |   |  | 23b. DATE<br><i>5-22-80</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Metropolitan Crem.</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Alexandria Va.</i>                     |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Robert A. Pumphrey</i>  |  |   |  |   |   | ADDRESS<br><i>Homes, P.A., Bethesda, Md.</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAY 27 1980</i>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

MEDICAL CERTIFICATION



Organization 5-11-55  
Robert A. Kennedy  
New York, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain this certificate for 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |   |  |  |
|---|--|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO. 8013402   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Edward Fabrey Saul</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 28, 1980</b>                                      |  |   | 2b. HOUR<br><b>8:05pm</b>                                      |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 4 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS                               |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Billor</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dental Lab.</b>        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Montg.</b> 13c. CITY OR TOWN <b>Kensington</b>  |  |  |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4501 Franklin Street</b>  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ella Polly</b>                              |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>578-03-3121</b>   |  | 17. INFORMANT ADDRESS<br><b>Virginia E. Saul (Same as 13e)</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Bilateral lung cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of Prostate</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>1-2 wks</u><br><u>Sev. years.</u> |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Diffuse bone metastasis</u>  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb-Mar</u> , 19 <u>80</u> , to <u>28 May</u> , 19 <u>80</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>28 May</u> , 19 <u>80</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <u>(did not)</u> view the body after death.   |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE <u>Donald E. Dillon</u> MD   |  |  |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>           |  |  |   | 22c. DATE SIGNED<br><u>29 May 80</u>                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Donald E. Dillon, M.D.</u>  |  |  |  | 22e. ADDRESS <u>18111 Pr Philip Dr Olney, Md 20832</u>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5-31-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery Suitland</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Md.</b>                          |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                               |   |  |  |

BP

[illegible]

BH

#13abcde, Film G552 2/3/81 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 1 3 4 0 3

REG. NO.

|   |  |  |  |   |                           |  |
|---|--|--|--|---|---------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELIZABETH LAUE SCHNEIDER</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 5, 1980</b> |   | 2b HOUR<br><b>8:14 PM</b> |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPTEMBER 19, 1920</b>                      |                           |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59 YRS.</b>  |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>D.C.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                           |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.   |  |   |                           |  |
| 10 CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE CLINICAL CENTER N.I.H.</b>                                   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |                           |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>   |  | 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE <b>Florida</b> 13c COUNTY <b>Collier</b> 13d CITY OR TOWN <b>Naples</b> |  |   |                           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEARHARD LAUE</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATHERINE WINTER</b>   |  |   |                           |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b SOCIAL SECURITY NO.<br><b>578-18-4365</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>DR. JOHN SCHNEIDER (NOK) SAME AS ABOVE</b>            |                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>vasculitis with interstitial lung disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>s/p oper. lung biopsy</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hours</b><br><b>1 years</b> |  |  |  |   |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |                           |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                           |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                           |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                           |  |
| 22a I certify that (this hospital) attended the deceased from <b>MARCH 29, 1980</b> to <b>MAY 5, 1980</b> , that (we) (I) saw the deceased alive on <b>MAY 5, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.  |  |  |  |   |                           |  |
| 22b SIGNATURE<br><b>John B. Harley</b>  |  | DEGREE<br><b>MD PhD</b>  |  | 22c DATE SIGNED<br><b>May 6, 1980</b>   |                           |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John B. Harley</b>   |  | 22e ADDRESS<br><b>NATIONAL INSTITUTES OF HEALTH<br/>CLINICAL CENTER, BETHESDA, MD 20205</b>  |  |   |                           |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>5/9/1980</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>                     |                           |  |
| 23d LOCATION<br>CITY OR TOWN<br><b>Washington, D.C.</b>   |  | 23e LOCATION<br>COUNTY<br><b>D.C.</b>  |  | 23f STATE<br><b>D.C.</b>  |                           |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Joseph Gawler's Sons Inc.</b><br>ADDRESS<br><b>5130 Wisc. Ave., N.W. Wash., D.C.</b>  |  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAY 9 1980</b>                                   |                           |  |
| 25b REGISTRAR'S SIGNATURE<br><b>Lifkey McCready</b>   |  |  |  |   |                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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10/27/78 11:00 AM 11:00 AM 11:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 1 3 4 0 4  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Anita (Anna) Schreiber  |  |   |  | 2a. DATE OF DEATH<br>5/19/80   |  | 2b. HOUR<br>1:05 PM  |  |
| 3. SEX<br>female  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>4 12 05  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>75 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Russia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hosp |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md.   |  | 13b. COUNTY<br>Mont.  |  | 13c. CITY OR TOWN<br>Sil Spr   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>Morris   |  | 15. MOTHER'S MAIDEN NAME<br>Goldie  |  | 16. STREET ADDRESS<br>1131 Hawth Blvd NW   |  |  |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 17b. SOCIAL SECURITY NO.<br>059-38-2811   |  | 17c. INFORMANT<br>Mr. Meyrowitz, 11704 Lovejoy St. Maryland  |  | 17d. ADDRESS<br>Silver Spring,   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cancer of Stomach with metastasis<br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 3/4 yrs.   |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17, 1980, to 5/19, 1980, that (I) (we) last saw the deceased alive on 5/19, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Alan Weinstock  |  |   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>5/19/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Alan Weinstock   |  |   |  | 22e. ADDRESS<br>1299 Lamberton Dr., Silver Spring, Md.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>5-20-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Hebron Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Flushing, N.Y.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>MAY 23 1980   |  |  |  |

BP

APR 2 1980

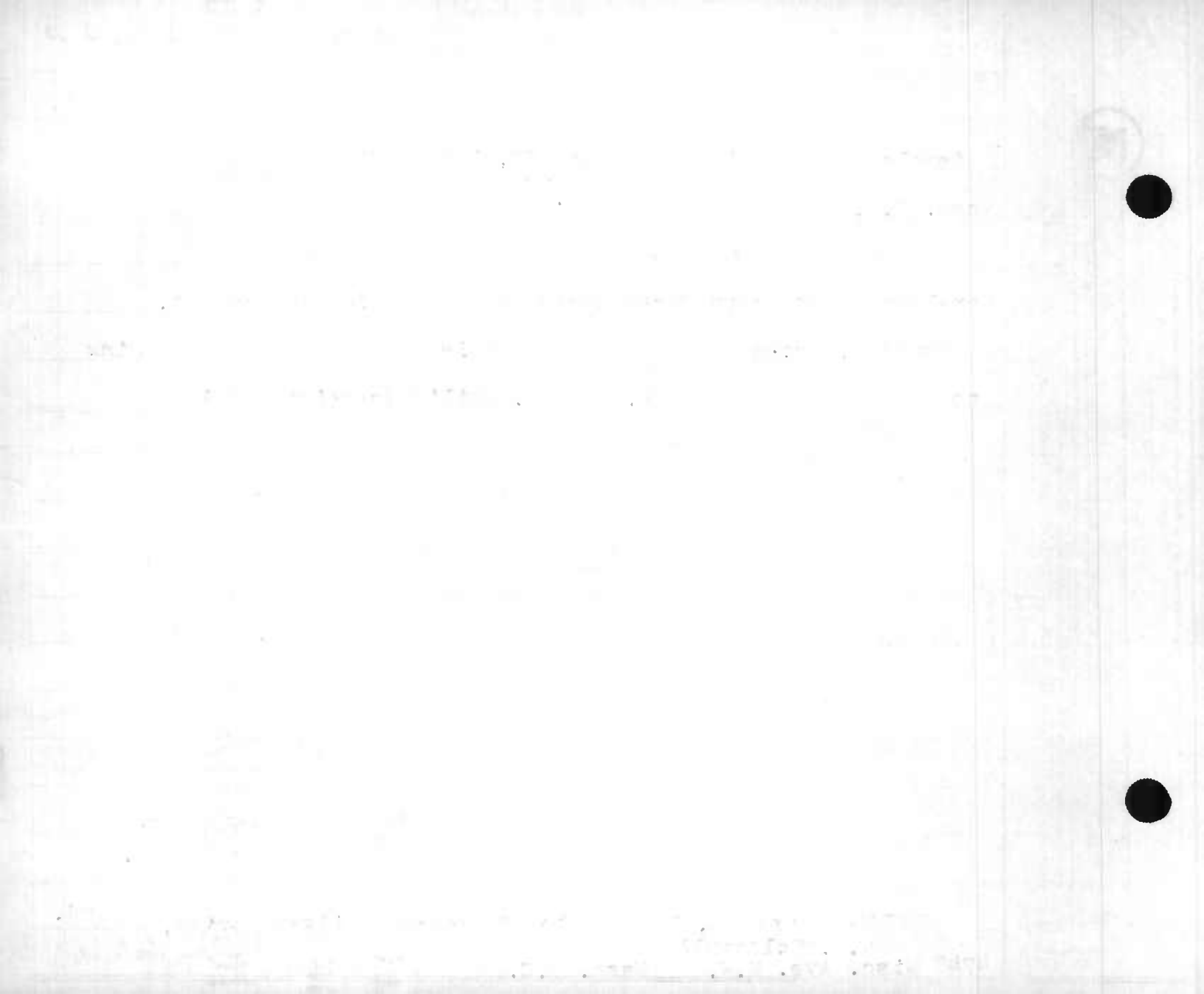


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 1 3 4 0 5   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>MARGARET M. SCHREIER  |  |  |  | 2a. DATE OF DEATH<br>5 16 80  |  | 2b. HOUR<br>2:55 P.M.  |   |
| 3. SEX<br>female  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>June 27, 1908   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash. D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Chevy Chase   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas P. Brown   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie King   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>UNK.  |  | 17. INFORMANT ADDRESS<br>E. Philip Schreier # 13  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arteriosclerotic Heart Disease</u>                                    |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immed</u><br><u>2d</u><br><u>4hr</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/79</u> , 19____, to <u>5/16/80</u> , 19____, that (I) (we) lost saw the deceased alive on <u>5/16/80</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br>Jeremy V. Cooke MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>5/16/80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jeremy V. Cooke  |  |  |  | 22e. ADDRESS<br>10900 Conn Ave. Kensington MD   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>May 19, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring Md.  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>W.W. Taltavull  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 20 1980  |  |  |   |
| 4748 Wisc. Ave. N.W. Wash. D.C.   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Lester A. Bailey  |  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

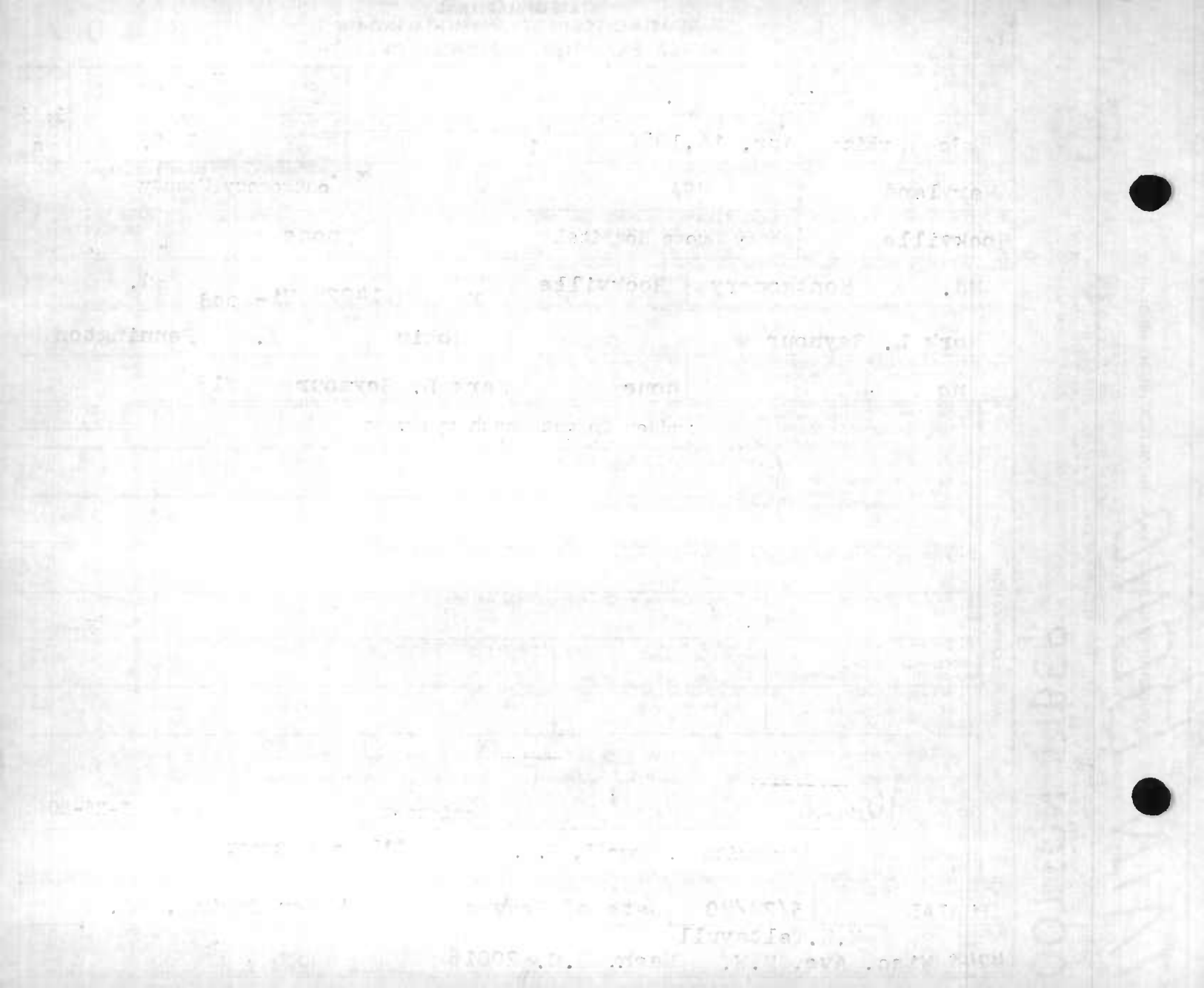
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |  |   |  | 8 0 1 3 4 0 6                    |   |
|--|---|--|---|--|----------------------------------|---|
| 1. FOR<br>STATE<br>REGISTRAR   |   |  | CERTIFICATE OF DEATH  |  |                                  |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |   |  | 2a DATE OF DEATH  |  |                                  | 2b HOUR   |
| Lev Victor Serdakovsky   |   |  | MAY 17 80   |  |                                  | 4 P.M.  |
| 3 SEX  | 4 RACE  | 5 DATE OF BIRTH  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7 IF UNDER 1 YEAR                |   |
| Male   | White   | MAY 12 1904  | 76 YRS.   |  | IF UNDER 24 HRS.                 |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                                  |   |
| Russia   | USA   |  | Montgomery MD.  |  |                                  |   |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |  | 12b KIND OF BUSINESS OR INDUSTRY |   |
| Bethesda   | Suburban Hospital   |  | Fed. Employee   |  | Retired                          |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |  |   |  |                                  |   |
| 13a STATE  | 13b COUNTY  | 13c CITY OR TOWN   | 13d INSIDE CITY LIMITS?   | 13e STREET ADDRESS   |                                  |   |
| Md.  | Mont.   | Bethesda   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 7539 Spring Lake Drive   |                                  |   |
| 14 FATHER'S NAME   |   |  | 15 MOTHER'S MAIDEN NAME   |  |                                  |   |
| Victor Serdakovsky   |   |  | Nina Mesiehev   |  |                                  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |  | 16b SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS             |   |
| None   |   |  | 061 26 7609   |  | Same as Above                    |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>431-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 Days<br>13 Days |   |  |   |  |                                  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |   |  |   |  |                                  |   |
| 19a DATE OF OPERATION  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?   |                                  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                  |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                  |   |
| 22a I certify that (I) (this hospital) attended the deceased from 19 28, to 17 MAY 19 80, that (I) (we) last saw the deceased alive on 17 May 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |  |   |  |                                  |   |
| 22b SIGNATURE<br>Lawrence H. Schainker M.D.  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                  | 22c DATE SIGNED<br>17 May 80                                  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lawrence H. Schainker  |   |  |   | 22e ADDRESS<br>5401 Western Ave. Wash.D.C.   |                                  |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |   | 23b DATE   |   | 23c NAME OF CEMETERY OR CREMATORY  |                                  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                     |
| Burial   |   | 5/20/80  |   | Holy Trinity Cemetery Jordanville  |                                  | N.Y.  |
| 24 FUNERAL DIRECTOR NAME<br>Hines/Rinaldi Funeral Home, Inc.   |   |  |   | 25a DATE REC'D. BY REGISTRAR   |                                  | 25b REGISTRAR'S SIGNATURE                                     |
| 11800 New Hampshire Ave., Silver Spring, Md.   |   |  |   | MAY 21 1980  |                                  | Lawrence H. Schainker   |

MAY 27 1980

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |   |  |   |  |  |  |   |                                   | REG. NO. 13407                               |  |
|--|---------|---|--|---|--|--|--|---|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE KNOWN OF DEATH                                     |  |   |  |  |  | 2b. MONTH DAY YEAR  |                                   | 7b. HOUR                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE KNOWN OF DEATH   |                                   | 2b. MONTH DAY YEAR                           |  |
| JUSTIN   |         | F.  |  | SEYMOUR   |  |  |  | 5 25 80   |                                   | 6:55 AM                                      |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.  |                                   | 2c. DATE PRONOUNCED DEAD                     |  |
| male   | white   | Apr. 16, 1980   |  | 1 YRS.  |  | 1 MONTHS   |  | HOURS MIN.  |                                   | 5 25 80                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                   | MD.  |  |
| Maryland   |         | USA   |  | WIDOWED   |  | DIVORCED   |  | Montgomery County   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF PREVIOUS LIFE) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Rockville  |         | Shady Grove Hospital  |  |   |  | none   |  |   |                                   |  |  |
| 13a. STATE   |         | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS  |  |   |                                   |  |  |
| Md.  |         | Montgomery  |  | Rockville   |  | YES  |  | 14228 H1-Wood Rd.   |                                   |  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |  |  |   |                                   |  |  |
| Mark L. Seymour  |         | Robin Y. Pennington   |  |   |  |  |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS  |  |   |                                   |  |  |
| no   |         | none  |  | Mark L. Seymour   |  | #13  |  |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 7980<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)  |         |   |  |   |  |  |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |   |  |   |  |  |  |   |                                   |  |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |  |  | 20. AUTOPSY?  |                                   |  |  |
|  |         |   |  |   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |   |                                   |  |  |
|  |         | HOUR A.M. MONTH DAY YEAR                                    |  |   |  |  |  |   |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  | CITY OR TOWN   |  | COUNTY  |                                   | STATE  |  |
|  |         |   |  |   |  |  |  |   |                                   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |  |   |  |  |  |   |                                   |  |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |  | DATE SIGNED   |  |  |  |   |                                   |  |  |
| Margarita A. Korell, M.D.  |         | Assistant   |  | 5-26-80   |  |  |  |   |                                   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |  |   |  |  |  |   |                                   |  |  |
|  |         | 111 Penn Street   |  |   |  |  |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (CITY OR TOWN)                                   |  | COUNTY  |                                   | STATE  |  |
| BURIAL   |         | 5/28/80   |  | Gate of Heaven  |  | Silver Spring, Md.   |  |   |                                   |  |  |
| 24. FUNERAL DIRECTOR NAME  |         | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |                                   |  |  |
| W.W. Taltavull   |         | MAY 28 1980   |  | [Signature]   |  |  |  |   |                                   |  |  |
| 4748 Wisc. Ave. N.W.   |         | Wash. D.C. 20016  |  |   |  |  |  |   |                                   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and include.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |   |  |                            |  |
|--|--|--|--|---|--|--|--|---|--|---|--|----------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 70 13408   |  |   |  | REG. NO.                               |  |   |  |   |  |                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST                                   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR 30 P.M.  |  |                            |  |
| Gordon   |  | H.   |  | Sharpe  |  |  |  | 5-12-80   |  | 8 P.M.  |  |                            |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)         |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  |                            |  |
| Male   |  | Caucasian  |  | Sept. 20, 1919  |  | 60 YRS.                                |  |   |  |   |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH    |  |   |  |   |  |                            |  |
| England  |  | U.S.A.   |  |   |  | Montgomery MD.                         |  |   |  |   |  |                            |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                            |  |
| Bethesda   |  | Suburban Hospital  |  |   |  |  |  | Accountant  |  | Communication   |  |                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS        |  |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |  |  |  |   |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 8006 Inspection House Road |  |
| Maryland Montgomery Potomac  |  |  |  |   |  |  |  |   |  |   |  |                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |   |  |   |  |                            |  |
| Not Available  |  |  |  | Not Available   |  |  |  |   |  |   |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO   |  |  |  | 17 INFORMANT ADDRESS  |  |   |  |                            |  |
| No   |  |  |  | 576-52-8116   |  |  |  | Nicki Sharpe, Same as #13   |  |   |  |                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 5849  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (b). Respiratory arrest   |  |  |  |   |  |  |  |   |  | 3 min.  |  |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c). Metabolic acidosis  |  |  |  |   |  |  |  |   |  | 2 days.   |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (c). Acute Renal Failure.   |  |  |  |   |  |  |  |   |  | 2 days.   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Acute myo cardial infarction, Alzheimer's Disease.  |  |  |  |   |  |  |  |   |  |   |  |                            |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                            |  |
|  |  |  |  |   |  |  |  |   |  |   |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |                            |  |
|  |  |  |  |   |  |  |  |   |  |   |  |                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |                            |  |
|  |  |  |  |   |  |  |  |   |  |   |  |                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 5-8-80, 1980, to 5-12-80, 1980, that (I) (the hospital) saw the deceased alive on 5-12-80, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |                            |  |
| 22b. SIGNATURE   |  |  |  | DEGREE  |  |  |  | 22c. DATE SIGNED  |  |   |  |                            |  |
| John F. Tauber   |  |  |  | MD  |  |  |  | 5-13-80   |  |   |  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |  |  |   |  |   |  |                            |  |
| John F. Tauber   |  |  |  | 8218 Wisconsin Ave. Bethesda  |  |  |  |   |  |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |                            |  |
| Cremation  |  |  |  | 5/14/80   |  | Metropolitan Crem.                     |  | Alexandria, Virginia  |  |   |  |                            |  |
| 24 FUNERAL DIRECTOR NAME   |  |  |  |   |  | 24b. ADDRESS                           |  | 25a. DATE BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                            |  |
| Robert A. Pumphrey   |  |  |  |   |  | Funeral Homes, P.A. Bethesda, Maryland |  | MAY 16 1980   |  | [Signature]   |  |                            |  |





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

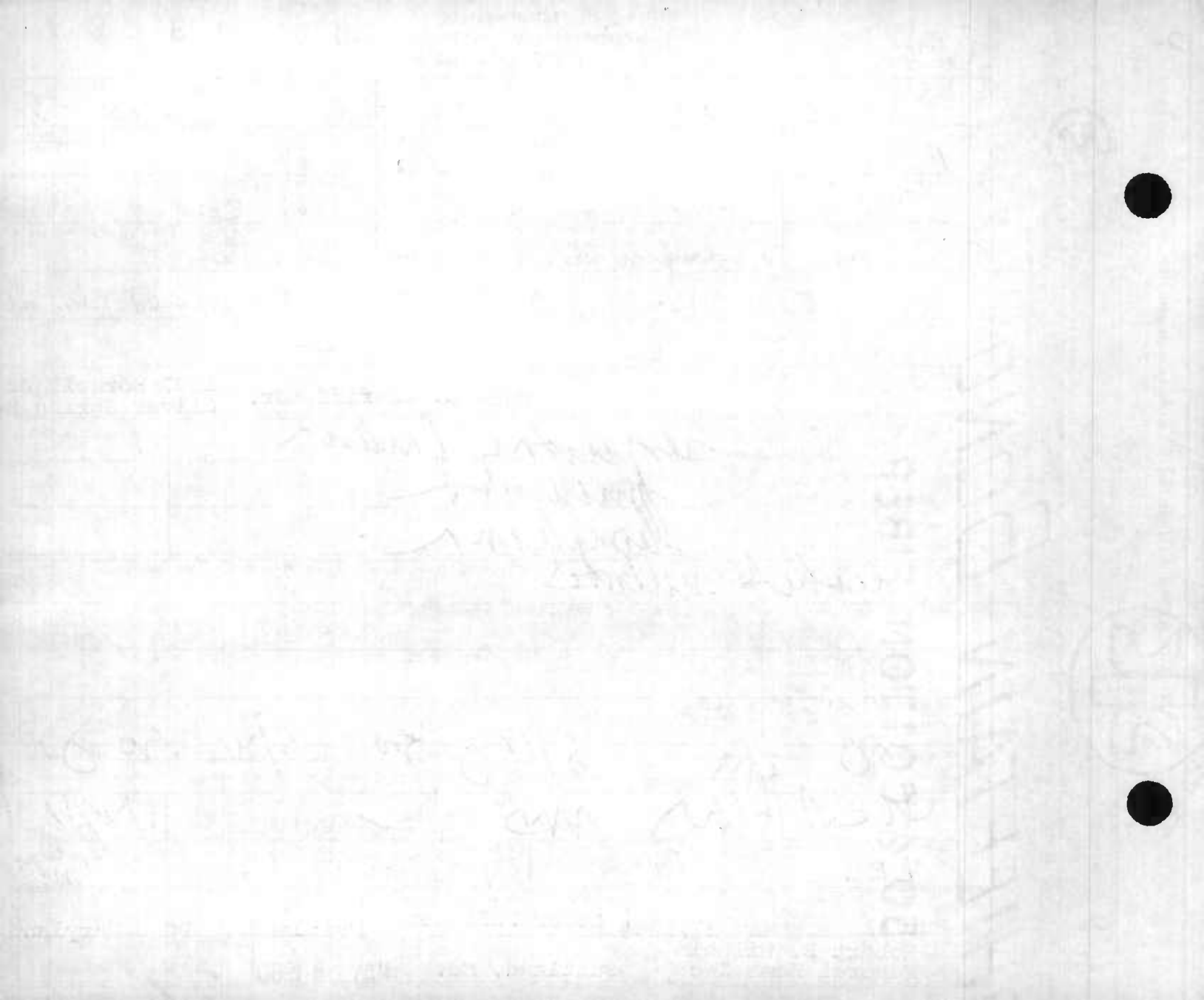
|  |   |   |   |   |                                      |
|--|---|---|---|---|--------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AIICE CATHERINE SHERIFF</b>   |   |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>24</b> YEAR <b>80</b>                      |   | 2b. HOUR<br><b>5<sup>55</sup> AM</b> |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>8</b> YEAR <b>1892</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                                     |                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Del</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Amer.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Mont. Co.</b> MD.                          |                                      |
| 10. CITY OR TOWN OF DEATH<br><b>Trk. Pk. md.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>hous. wife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY    |
| 13a. STATE<br><b>md.</b>   |   | 13b. COUNTY<br><b>Mont.</b>   | 13c. CITY OR TOWN<br><b>5404 Blad. md</b>   | 13e. STREET ADDRESS<br><b>5404 Annapolis Rd Blad. md.</b>                             |                                      |
| 14. FATHER'S NAME<br>FIRST <b>David</b> MIDDLE <b>Hartman</b> LAST <b>Bowen</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Carrie</b> MIDDLE <b></b> LAST <b></b>   |   |   |                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>110</b>  |   | 17. INFORMANT<br>ADDRESS <b>Wade H. Sheriff, Jr. 1207 Hornell Dr Silver Spring Md</b> |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>hypertension</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>dissecting aortic aneurysm</b> |   |   |   |   |                                      |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |                                      |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |   |   |                                      |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |                                      |
| 22a. I certify that (I) this hospital attended the deceased from <b>5/18/80</b> to <b>5/24/80</b> , that (I) (we) last saw the deceased alive on <b>5/18/80</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)  |   |   |   |   |                                      |
| 22b. SIGNATURE<br><b>John R. Lewis</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>5/24/80</b>  |                                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LEWIS DENNIS</b>   |   | 22e. ADDRESS<br><b>831 University Blvd Silver Spring Md 20903</b>   |   |   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>May 27, 1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem</b>                           |                                      |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland PG Maryland</b>  |   | 24. FUNERAL DIRECTOR<br>NAME <b>Robert E. Wilhelm</b> ADDRESS <b>Suitland, Md.</b>  |   |   |                                      |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia A. Brady</b>  |   |   |                                      |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1 - FOR STATE REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | REG. NO. 8 0 1 3 4 1 0   |  |
|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Eva T. Sherman</b>   |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>5</b> YEAR <b>80</b>  |  | 2b. HOUR <b>10</b> P <b>M</b>  |  |
| 3 SEX<br><b>female</b>  | 4 RACE<br><b>white</b>  | 5 DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>25</b> YEAR <b>93</b>   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>  | 7. IF UNDER 1 YEAR<br>MONTHS <b>YRS.</b> DAYS <b>HOURS</b> MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Turkey</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                        |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rockville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Potomac Valley Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>                                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Potomac</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>9017 Paddock Lane</b>                                      |  |  |
| 14 FATHER'S NAME<br>FIRST <b>Israel</b> MIDDLE <b>Touirkow</b>  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>LAST</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   | 16b. SOCIAL SECURITY NO.<br><b>040 44 7658</b>  | 17 INFORMANT<br>ADDRESS<br><b>Alexander Sherman same as 13e</b>  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Toxemia</b><br><b>4439</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Gangrene, right leg</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Peripheral vascular disease</b>   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b><br><b>2 months</b><br><b>years</b>                         |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Coronary heart disease</b>   |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>2/9</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/11</b> 19 <b>73</b> to <b>5/5</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/21</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Sidney J. Cohen</b>  |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>5/6/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sidney J. Cohen</b>   |   | 22e. ADDRESS<br><b>121 Congressional Lane Rockville, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>5/9/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Riverview Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dayton Ohio</b>                     |  |
| 24 FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home, Inc.</b><br>NAME ADDRESS<br><b>1331 Rockville Pike Rockville, Maryland</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 12 1980</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffery McCreedy</b>  |

10 10 0

|           |            |           |            |
|-----------|------------|-----------|------------|
| Rockville | Montgomery | Rockville | Montgomery |
| Rockville | Montgomery | Rockville | Montgomery |
| Rockville | Montgomery | Rockville | Montgomery |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item #6 per phone call w/Fuh. Home  |  |  |   |   |                                    |  |   |  |  |
|---|--|--|---|---|------------------------------------|--|---|--|--|
| STATE OF MARYLAND   |  |  |   |   |                                    |  |   |  |  |
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   |                                    |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |   |   |                                    |  |   |  |  |
| REG. NO. 8013411  |  |  |   |   |                                    |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST   |   |                                    | 2a. DATE OF DEATH MONTH DAY YEAR   |   |  | 2b. HOUR                                     |
| EDWARD  |  |  | SHIPPER   |   |                                    | 5-8-80   |   |  | 630 PM                                       |
| 3 SEX   |  | 4 RACE   |   | 5 DATE OF BIRTH MONTH DAY YEAR  |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)   |   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS                             |  |
| Male  |  | Caucasian  |   | Sept. 20, 1892  |                                    | 77 87 YRS.   |   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |  |  |
| Austria   |  | USA  |   |   |                                    | Montgomery County MD.  |   |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Silver Spring   |  | Holy Cross Hospital  |   |   |                                    | Foreman  |   | Gasket Co.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   | 13b. CITY OR TOWN   |                                    | 13c. INSIDE CITY LIMITS?   |   | 13d. STREET ADDRESS  |  |
| D. C.   |  |  |   | None  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 2101 16th Street, N. W.  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                           |   |                                    |  |   |  |  |
| Phillip ----- Shipper   |  |  | Tillie ----- Rottenstrich   |   |                                    |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |   |                                    | 17. INFORMANT ADDRESS  |   |  |  |
| No  |  |  | N/A   |   |                                    | Michigan   |   |  |  |
|   |  |  | 378-05-3791   |   |                                    | Mr. Wolok, 26640 Greenfield Rd., Oak Park,                                     |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c):   |  |  |   |   |                                    |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSECTIC CARDIOVASCULAR DISEASE   |  |  |   |   |                                    |  |   |  |  |
| 4292  |  |  |   |   |                                    |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |                                    |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |  |   |   |                                    |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |   |                                    |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |                                    |  |   |  |  |
| Occlusion Femoral Artery, Right, Acute  |  |  |   |   |                                    |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |                                    | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |   |   |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.                   |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |
|   |  |  | 19  |   |                                    |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |  |
|   |  |  |   |   |                                    |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 16, 1980, to MAY 8, 1980, that (I) (we) last saw the deceased alive on MAY 8, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |                                    |  |   |  |  |
| 22b. SIGNATURE  |  |  | DEGREE  |   |                                    | 22c. DATE SIGNED   |   |  |  |
| Bernard A. Fitzgerald MD  |  |  |   |   |                                    | 5-8-80   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |   |                                    |  |   |  |  |
| BERNARD A. FITZGERALD   |  |  | 217 UNIVERSITY BLVD E. SILVER SPRING, MD                            |   |                                    |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |  |
| Burial  |  |  | 5-11-80   |   | Machpelah Cemetery                 |  | Detroit, Wayne, Michigan                |  |  |
| 24 FUNERAL DIRECTOR NAME ADDRESS  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE              |  |  |
| DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.  |  |  |   |   | MAY 14 1980                        |  | Rufus McCreedy                          |  |  |





TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | REG. NO. 13412  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2r. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Adelaide</u> <u>SILVA</u>   |  |   |  | 2b. HOUR <u>6:55</u> P.M.   |  |  |  |
| 3 SEX <u>Female</u>   |  | 4 RACE <u>White</u>   |  | 5 DATE OF BIRTH MONTH DAY YEAR <u>1 29 96</u>                                     |  | 6 AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS.  |  |
| 7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Brazil</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>Brazil</u>  |  | 8. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS.                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery Co.</u> MD.   |  |
| 10 CITY OR TOWN OF DEATH <u>Bethesda</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>    |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>   |  |
| 13a. STATE <u>Maryland</u>  |  | 13b. COUNTY <u>Montgomery</u>   |  | 13c. CITY OR TOWN <u>Chevy Chase</u>  |  | 13d. STREET ADDRESS <u>4450 So Parker Ave #501</u>   |  |
| 14 FATHER'S NAME FIRST <u>Jose</u> MIDDLE <u>Moreira</u> LAST <u>Moreira</u>  |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Rosa</u> MIDDLE <u>(Unknown)</u> LAST <u>(Unknown)</u>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>        |  |  |  |
| 16b. SOCIAL SECURITY NO <u>579-54-0459</u>  |  | 17 INFORMANT ADDRESS <u>Maria A. Cabral, Same as # 13.</u>  |  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> (b) <u>Hypertensive Atherosclerotic Heart Disease</u> (c) <u>Hypertensive Cardiovascular Disease</u> |  |
| 19a. DATE OF OPERATION <u>5/19/80</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Type II Hyperlipoproteinemia</u>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>Feb</u> 19 <u>60</u> , to <u>5/15</u> 19 <u>80</u> , that (1) (we) last saw the deceased alive on <u>5/15</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death) |  |   |  |   |  |  |  |
| 22b. SIGNATURE OF ATTENDING PHYSICIAN <u>Michael M. Healy MD</u>  |  |   |  | 22c. DATE SIGNED <u>5/15/80</u>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michel M. HEALY MD</u>  |  |
| 22e. ADDRESS <u>5652 Shields Dr., Bethesda, MD</u>  |  |   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>                           |  |  |  |
| 23b. DATE <u>5/19/80</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>   |  | 23d. LOCATION CITY OR TOWN <u>Silver Spring, Maryland</u>                         |  | 23e. DATE REC'D. BY REGISTRAR <u>MAY 21 1980</u>   |  |
| 24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>   |  |   |  | 25b. REGISTRAR'S SIGNATURE <u>Patricia K. Murphy</u>                              |  |  |  |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016   |  |   |  |   |  |  |  |

56003 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Released by Dr. Frances Shayle

5/19/80 7:10 PM

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "information" and "type" are faintly visible.]*

*[Handwritten signature or initials.]*

MAY 21 1960

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |   |  |  |  | REG. NO.  |   |  |  |                                    |  |
|--|--|--|---|---|--|---|--|--|--|---|---|--|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA SILVER</b>   |  |  |   |   | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>15</b> YEAR <b>80</b>                 |   | 2b. HOUR<br><b>12:45 PM</b>  |  |  |   |   |  |  |                                    |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>DEC.</b> DAY <b>21</b> YEAR <b>1893</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>       |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                                |   |  |  |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                               |  |  |  |   |   |  |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hebrew Home of Greater Wash.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b> |  |   |   |  |  |                                    |  |
| 13a. STATE<br><b>D.C.</b>  |  |  |   |   | 13b. COUNTY<br><b>none</b>   |   | 13c. CITY OR TOWN<br><b>WASHINGTON</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   | 13e. STREET ADDRESS<br><b>4911 BAYARD BOULEVARD</b> |  |  |                                    |  |
| 14. FATHER'S NAME<br>FIRST <b>MAX</b> MIDDLE <b></b> LAST <b>HABER</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>DORA</b> MIDDLE <b></b> LAST <b>NESSING</b> |   |  |  |  |   |   |  |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>579-48-4259D</b>                                  |   | 17. INFORMANT<br><b>Exec. dir. 6121 MONTROSE ROAD, SAMUEL ROBERTS, ROCKVILLE, MARYLAND</b> |  |  |   |   |  |  |                                    |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b><br><b>599D</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>URINARY INFECTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PSEUDOMONAS AERUGINOSA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b>                 |   |  |  |                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>SEVERE SENILE DEMENTIA</b>  |  |  |   |   |  |   |  |  |  |   |   |  |  |                                    |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/21/76</b> P.M. <b>19</b> |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |  |  |  |   |   |  |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>6121 MONTROSE RD, ROCKVILLE, MD</b> |  |  |  |   |   |  |  |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/21/76</b> to <b>5/15/80</b> , that (I) (we) last saw the deceased alive on <b>5/15/80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |  |  | 22b. SIGNATURE<br><b>D.D. PATEL</b>   |   | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/15/80</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  |  |   |   | 23b. DATE<br><b>5/16/1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT LEBANON CEMETERY</b>                        |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ADELPHI PR. GEORGES, MD.</b> |   |  |  |                                    |  |
| 24. FUNERAL DIRECTOR<br><b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>  |  |  |   |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 19 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey McCready</b>  |   |   |  |  |                                    |  |
| 232 CARROLL STREET, N. W. WASHINGTON, D. C.  |  |  |   |   |  |   |  |  |  |   |   |  |  |                                    |  |

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APR 11 1953

WHITE

NEW YORK

OWN HOME

HOUSEWIFE

1011 E/VANU BOULEVARD

WASHINGTON

HONG

WESTING

JOHN

MAKER

UX

JOHN, JR. 1810 TWOSE ROAD  
KNOXVILLE, TENNESSEE

WASHINGTON AND REGION

WASHINGTON MOUNT LEBANON CEMETERY ARLING PT. GROVER, MD.

ST. JOHN'S CEMETERY ARLING PT. GROVER, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  | REG. NO.   |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  | 2b. HOUR   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARGARET J. SINDELAR</b>  |  |  |  |  |  | <b>5/31/80</b>   |  |   |  | <b>12<sup>30</sup> AM</b>  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>5 unk 1893</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Nebraska</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Olney</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Brooke Grove Nursing Home</b> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>                                    |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |  |  |   |  |  |  |
| 13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Montgomery</b>  |  | 13c CITY OR TOWN<br><b>Rockville</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>1904 Henry Road</b>  |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Frank Pakos</b>  |  |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Josephine Broz</b>                             |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  |  |  | 16b SOCIAL SECURITY NO.<br><b>522 42 8164</b>  |  | 17 INFORMANT ADDRESS<br><b>Gilbert E. Sindelar same as 13e</b>                                 |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>436 - CEREBRAL INSUFFICIENCY</b><br>DUE TO, OR AS COMPLICATED BY<br><b>CEREBRAL ARTERIOSCLEROSIS</b><br>(b)<br>DUE TO, OR AS COMPLICATED BY<br><b>CEREBROVASCULAR DIS.</b><br>(c)<br><b>MULTIPLE STROKES - VASCULAR</b> |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>NOTHS</b><br><b>YRS</b><br><b>YES.</b>      |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><b>MULTIPLE STROKES - VASCULAR</b>   |  |  |  |  |  |  |  |   |  |  |  |
| 19a DATE OF OPERATION<br><b>—</b>   |  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |  |   |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>4/16</b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>75 5/31 80</b>                            |  |   |  |  |  |
| 22a I certify that (1) (this hospital) attended the deceased from <b>4/16</b> to <b>5/31</b> , that (1) (was) last saw the deceased alive on <b>5/31</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (was) (did) not view the body after death.   |  |  |  |  |  |  |  |   |  |  |  |
| 22b SIGNATURE<br><b>D. R. LEWIS MD</b>  |  |  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>5/31/80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. R. LEWIS MD</b>  |  |  |  |  |  | 22e ADDRESS<br><b>OLNEY, Md 20832</b>  |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>6/4/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crown Hill Cemetery</b>                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Denver, Colorado</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Byson Wheeler Funeral Home, Inc.</b><br><b>1331 Rockville Pike Rockville Md.</b>   |  |  |  |  |  | 25a. DATED BY<br><b>JUN 5 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |  |  |  |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 0 1 3 4 1 5   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |   |   |
| CATHERINE S. SMITH   |  |   |  | 5- 5 11 80 10:45 AM   |  |   |   |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                   |   |
| FEMALE   |  | CAUCASIAN   |  | 10 20 99  |  | 80 YRS.   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                              |   |
| MARYLAND   |  | U.S.  |  |   |  | MONTGOMERY COUNTY MD.   |   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                              |   |
| Rockville  |  | SHADY GROVE ADVENTIST HOSPITAL  |  | RETIRED   |  |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?  |  |   |   |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |
| MARYLAND MONTGOMERY GAITHERSBURG   |  |   |  | 13e. STREET ADDRESS   |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |   |
| Charles J. Stockman  |  |   |  | Mary L. Corridon  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO   |  |   |   |
| No.  |  |   |  | 215481453   |  |   |   |
| 17. INFORMANT<br>ADDRESS   |  |   |  | 3509 So. Leisure World Blvd.<br>Annabel Stockman, (Sister)  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Myocardial Infarction  |  |   |  |   |  |   | Days  |
| 410 - DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |   |
| (b) Coronary Artery Atherosclerosis  |  |   |  |   |  |   | years   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |   |
| (c) Generalized Atherosclerosis  |  |   |  |   |  |   | years   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |   |
| Cerebral Vascular Insufficiency  |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
|  |  |   |  |   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 19 72 to April 11 1980, that (I) (we) last<br>saw the deceased alive on April 11 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE   |  |   |  | DEGREE  |  | 22c. DATE SIGNED  |   |
| Harris M. Kenner   |  |   |  | MD  |  | 5/11/80   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |  |   |   |
| HARRIS M. KENNER MD  |  |   |  | 10401 OH Georgetown Rd. Bethesda and 20014  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                        |   |
| Burial   |  | May 14, 1980  |  | Woodland -  |  | Washington, DC  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |   |
| JARTHAN WALTERS 254 CARROLL ST NW WASH DC  |  |   |  | MAY 14 1980   |  | J. H. Walters   |   |



Thomson, James (1847-1907)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 4 1 6  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |                         |   |   |  |  |  |  |   |  |
|--|--|-------------------------|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edna R Smith</b>                    |  |                         | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>7</b> YEAR <b>80</b>   |   |  | 2b. HOUR<br><b>8:45</b> AM   |  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b> |   | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>26</b> YEAR <b>08</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b> |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. State</b>            |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>9. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                          |  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Firestone</b>   |  |
| 13a. STATE<br><b>Md</b>  |  |                         | 13b. COUNTY<br><b>Montg.</b>  |   |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Archie</b> MIDDLE <b>Lu</b> LAST <b>Core</b> |  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lottie</b> MIDDLE <b>Singer</b> LAST <b>Singer</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  |  | 16b. SOCIAL SECURITY NO<br><b>557-26-6426</b>   |  |
| 17. INFORMANT (sister) ADDRESS<br><b>Louetta Sivertson- (same as 13e)</b>  |  |                         |   |   |  |  |  |  |   |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY INSUFFICIENCY</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b> |  |
| 496-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>HERPES ZOSTER</b> |  | <b>2 YEARS</b>  |  |

|  |  |   |  |
|--|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>HERPES ZOSTER</b>   |  |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>NO</b>   |  | 21b. TIME OF INJURY<br>HOUR A.M. <b>11:00</b> DAY <b>19</b> P.M. <b>19</b>  |  |
| 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b>  |  | 21d. LOCATION<br>STREET <b>N/A</b> CITY OR TOWN <b>N/A</b> COUNTY <b>N/A</b> STATE <b>N/A</b>   |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b>   |  | 21f. LOCATION<br>STREET <b>N/A</b> CITY OR TOWN <b>N/A</b> COUNTY <b>N/A</b> STATE <b>N/A</b>   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>August 19 74</b> to <b>5/2/80</b> , that (I) (we) lost saw the deceased alive on <b>5/2/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |
| 22a. SIGNATURE<br><b>D. J. Hand</b>  |  | 22b. DATE SIGNED<br><b>5/7/80</b>   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DENNIS J. HAND MD</b>  |  | 22d. ADDRESS<br><b>4600 CONNECTICUT AVE NW. WASH DC.</b>  |  |

|   |  |                             |  |  |  |  |  |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                            |  | 23b. DATE<br><b>5-10-80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Rockville</b> COUNTY <b>Montgomery</b> STATE <b>Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Warner E. Pumphrey, Inc.</b><br>8434 Ga. Ave., S.E. S. Md. |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 12 1980</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. Hand</b>  |  |



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  |   |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | Elizabeth Ledig Smith   |  | May 1, 1980   |  | 9:15a  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7. IF UNDER 1 YEAR   |  |
| Female   |  | Caucasian  |  | Jan. 29, 1907   |  | 73 YRS.   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |  |
| Louisiana  |  | USA  |  |   |  | Montgomery County, MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  |  |  |
| Rockville  |  | Collingswood Nursing Home  |  |   |  |   |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |   |  |  |  |
| Homemaker  |  | Home   |  |   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS   |  |  |  |
| Md.  |  | Montg.   |  | Silver Spring   |  | 733 Sligo Avenue  |  |  |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |   |  |  |  |
| Henry  |  | Emma   |  | No  |  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT   |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |
| 578-07-1612  |  | Gerry H. Smith   |  | PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u>  |  |   |  |  |  |
|  |  |  |  | 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary arteriosclerosis</u>  |  |   |  |  |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 years.</u>   |  |   |  |  |  |
|  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mins.</u>   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10 years.</u>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (the undersigned) attended the deceased from <u>Dec</u> , 19 <u>75</u> to <u>May 1</u> , 19 <u>80</u> , that (I) <u>last</u> saw the deceased alive on <u>May 1</u> , 19 <u>80</u> , and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> <u>not</u> view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |  |  |
| <u>John Tauber</u>   |  | <u>M.D.</u>  |  | May 1, 1980   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |  |  |
| John F. Tauber, M.D.   |  | 8218 Wisconsin Ave. Bethesda, Maryland   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |  |  |
| Burial   |  | May 3, 1980  |  | George Washington Cem.  |  | Adelphi, Md.  |  |  |  |
| 24 FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Robert A. Pumphrey Funeral Homes, P.A.   |  | Bethesda, Md.  |  | MAY 8 1980  |  | <u>Robert A. Pumphrey</u>   |  |  |  |



2:15

75

1901

1901

Louisiana

Rockville

Silver Spring

Rockville

Rockville

578-07-1012 Gerty Smith

Caroline G. West

Caroline G. West

May 1, 1901

May 1, 1901

May 1, 1901

May 1, 1901

May 1, 1901

May 1, 1901

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

1 3 4 1 8

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Julia Plossi Smith                  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 30 1980 |  |  | 2b. HOUR<br>12:15 PM  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Caucasian  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>May 21 1911   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>69                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD. |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                     |  |
| 13a. STATE<br>S. Carolina  |  |  |  | 13b. CITY OR TOWN<br>Charleston  |  | 13c. STREET ADDRESS<br>1812 Summer Avenue                     |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph (none) Plossi              |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anastasia not available  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>199-07-0493  |  | 17 INFORMANT<br>ADDRESS<br>Peter Plossi 327 W. 15th; ShipBottom, N. Jersey   |  |   |  |

|  |  |  |  |
|--|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Bronchopneumonia &amp; Congestive Heart Failure</u><br>(c) <u>Arteriosclerotic Cardiovascular Disease</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--|--|--|--|

|   |  |   |  |
|---|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>April 23</u> , 19 <u>80</u> , to <u>May 30</u> , 19 <u>80</u> , that <u>X</u> (we) lost saw the deceased alive on <u>May 30</u> , 19 <u>80</u> , and that in (my) <u>XX</u> opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death. |  |   |  |
| 22b. SIGNATURE<br><u>Jeffrey M. Crane</u>   |  | 22c. DATE SIGNED<br><u>June 22 1980</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jeffrey M. Crane   |  | 22e. ADDRESS<br>National Naval Medical Center, Bethesda, MD   |  |

|   |  |                           |  |   |  |  |  |
|---|--|---------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                       |  | 23b. DATE<br>June 5, 1980 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Carolina Memorial Gar |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Charleston S. Carolina |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND |  |                           |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 4 1980                 |  |  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |                           |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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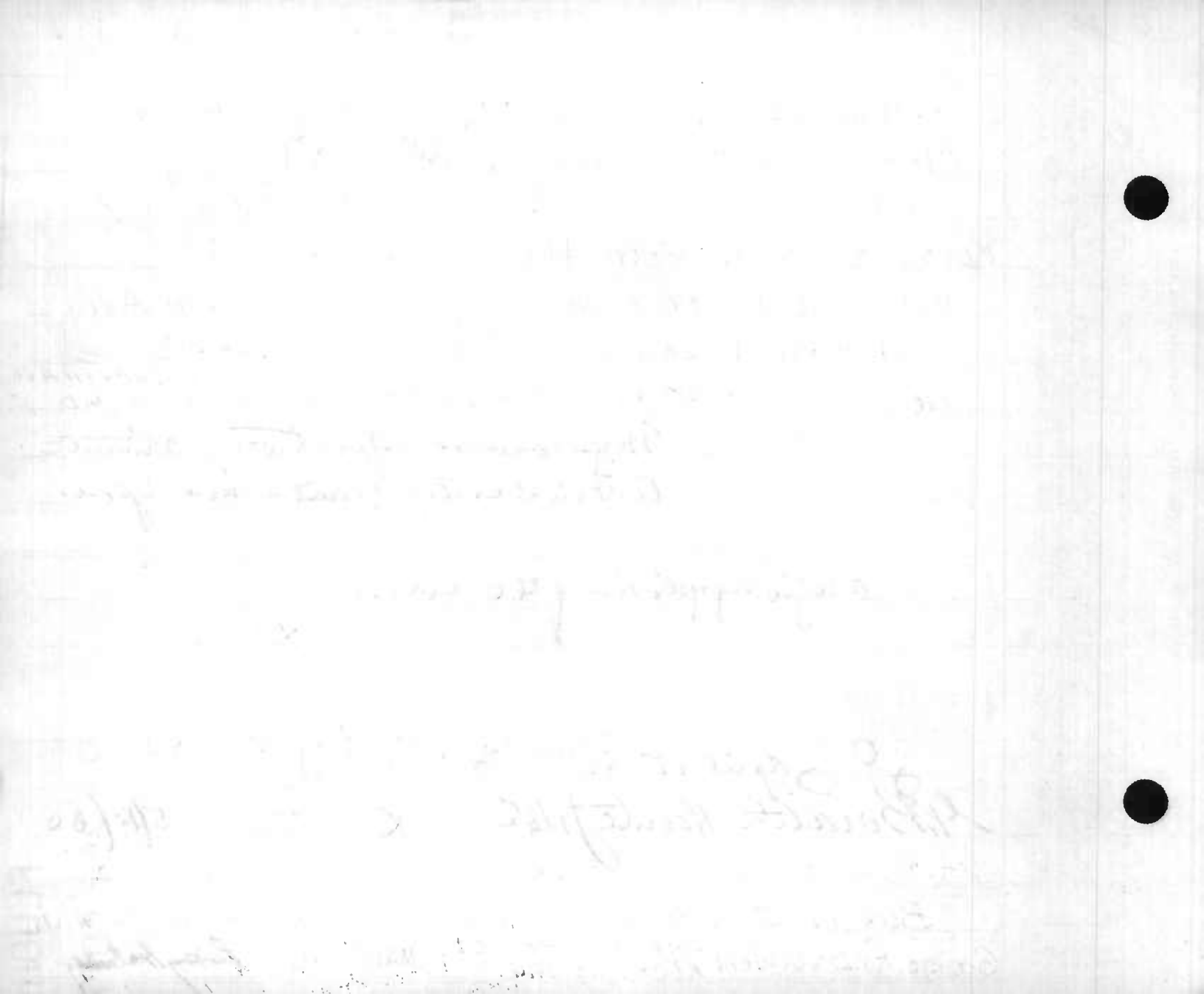


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1. STATE<br>REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 1 3 4 1 9  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Raymond P. Smith  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 15 1980   |  |  |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug 1 1928   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.                               |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 7b. IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rockville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SHADY GROVE ADVENTIST HOSP. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   |  | 13b. COUNTY<br>Montg.   |  | 13c. CITY OR TOWN<br>Rockville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>337 LINCOLN AVE.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>U. GRANT SMITH   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CLARISEY HARRIS   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>217-42-3271   |  | 17. INFORMANT ADDRESS<br>MABEL HAWKINS 219 ELIZABETH AVE. ROCKVILLE MD.  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Atherosclerotic heart disease years<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes                              |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>angiodysplasia of the colon  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |
| 22a. I certify that (i) (this hospital) attended the deceased from March 30 1979 to May 15 1980, that (i) (we) last saw the deceased alive on April 15 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (ii) (did) and not view the body after death.   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE OF PHYSICIAN<br>G. Boudette Hunter MD  |  |   |  |   |  |  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>5/16/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. Boudette Hunter MD  |  |   |  |   |  |  |  | 22e. ADDRESS<br>50 W Edmonston Drive Rockville, Md. 20850                            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |   |  | 23b. DATE<br>5-20-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Park Cem.                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Rockville Montg Md.                       |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>George R. Snowden  |  |   |  | 24b. ADDRESS<br>246 N. Wash. St. Rockville, Md.   |  | 25a. DATE REC'D BY REGISTRAR<br>MAY 21 1980                              |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. [Signature]                                      |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |   |   |  |
|--|--|--|---|--|--|---|---|---|--|
| 1- FOR STATE REGISTRAR   |  |  |   |  |  |   |   |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Robert A. SMYTH  |  |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>May 18 1980   |   |   | 2b HOUR<br>7:10P M  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Caucasian  |   | 5 DATE OF BIRTH MONTH DAY YEAR<br>June 4 1897  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |   | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>National Naval Medical Center |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U.S. Coast Guard |   | 12b KIND OF BUSINESS OR INDUSTRY<br>Coast Guard   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>D.C.   |  | 13b COUNTY<br>Washington   |   | 13c INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d STREET ADDRESS<br>3003 Vaness Street, South                                     |   |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>David Biger Smyth  |  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Frances Smith  |   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>WWII  |   | 17 INFORMANT ADDRESS Washington, D.C.<br>Mr. Arthur G. Nichols, Jr, 725 15th St. N.W.  |  |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>496-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>End-Stage Chronic Obstructive Lung Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |   |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>May 11</u> 19 <u>80</u> to <u>May 18</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>May 18</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |   |   |  |
| 22b SIGNATURE<br><u>Marina Vihki Vernalis</u>  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c DATE SIGNED<br>May 20, 1980   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marina M. Vernalis, M, D,  |  |  |   |  | 22e ADDRESS<br>National Naval Medical Center, Bethesda, Md.  |   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>6/2/1980   |   | 23c NAME OF CEMETERY OR CREMATORY<br>Arlington National  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Va.                          |   |   |  |
| 24 FUNERAL DIRECTOR NAME<br>Jos. Gawler Sons   |  |  |   |  | ADDRESS<br>Washington, D.C.  |   | 25a DATE REC'D. BY REGISTRAR<br>MAY 27 1980 |   | 25b REGISTRAR'S SIGNATURE<br><u>propy McCreedy</u> |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 3 4 2 1  
CERTIFICATE OF DEATH

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |   |   |   |   |   |   |  |
|---|--|---|--|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Barnard Paul Sollers, Jr.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-28-80</b>                    |  |   | 2b. HOUR<br>MIN<br><b>7:45 AM</b>   |   |   |   |   |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-16-33</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, D. C.</b>     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |   |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ELECTRICAL ENG.</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BECHTEL</b>             |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>MONTGOMERY</b>   |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>12108 CENTERHILL STREET</b> |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BERNARD PAUL SOLLERS, SR.</b> |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HELLANE E. JAMES</b> |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE WAR OR DATES<br><b>KOREAN</b> |   |   |   | 16b. SOCIAL SECURITY NO<br><b>214-32-9844</b> |  |
| 17 INFORMANT<br><b>BROTHER</b>  |  |   | ADDRESS<br><b>4591 61 LANE NORTH</b>                                     |  |   | 17. INFORMANT<br><b>JOHN JAMES SOLLERS, SR.</b>   |   |   |   | Kenneth City, Fla.                            |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

**1579**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**2 weeks****4 months**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (if this hospital) attended the deceased from <b>5/18</b> 19 <b>80</b> , to <b>5/28</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>5/27</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Michael R. Dobridge MD</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>5/28/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael R. Dobridge MD</b>   |  |  |  | 22e. ADDRESS<br><b>13975 Connecticut Ave Silver Spring, Md</b>                 |  |  |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>5/31/80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SILVER SPRING MONT MD.</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 29 1980</b>         |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>                        |  |
| 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901               |  |                             |  |   |  |   |  |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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500 LINDEN BLVD. N. SILVER SPRING, MD. 20901  
FRANCIS J. COLLINS  
MAY 3 1980

GRITAL 5/21/80 GATE OF HEAVEN SILVER SPRING MD.

VTS KOREAN 214-32-9844 JOHN JAMES COLLINS, SR. KENNEDY CIRCLE, F.D.  
BERNARD PAUL COLLINS, SR. HELLAM F. JAMES  
1591 E LANE NORTH

MARYLAND MONTGOMERY SILVER SPRING X 12100 CONVENTHILL STREET

WASHINGTON, D. C. U.S.A. WHITE  
ELECTRICAL ENG. MICHAEL

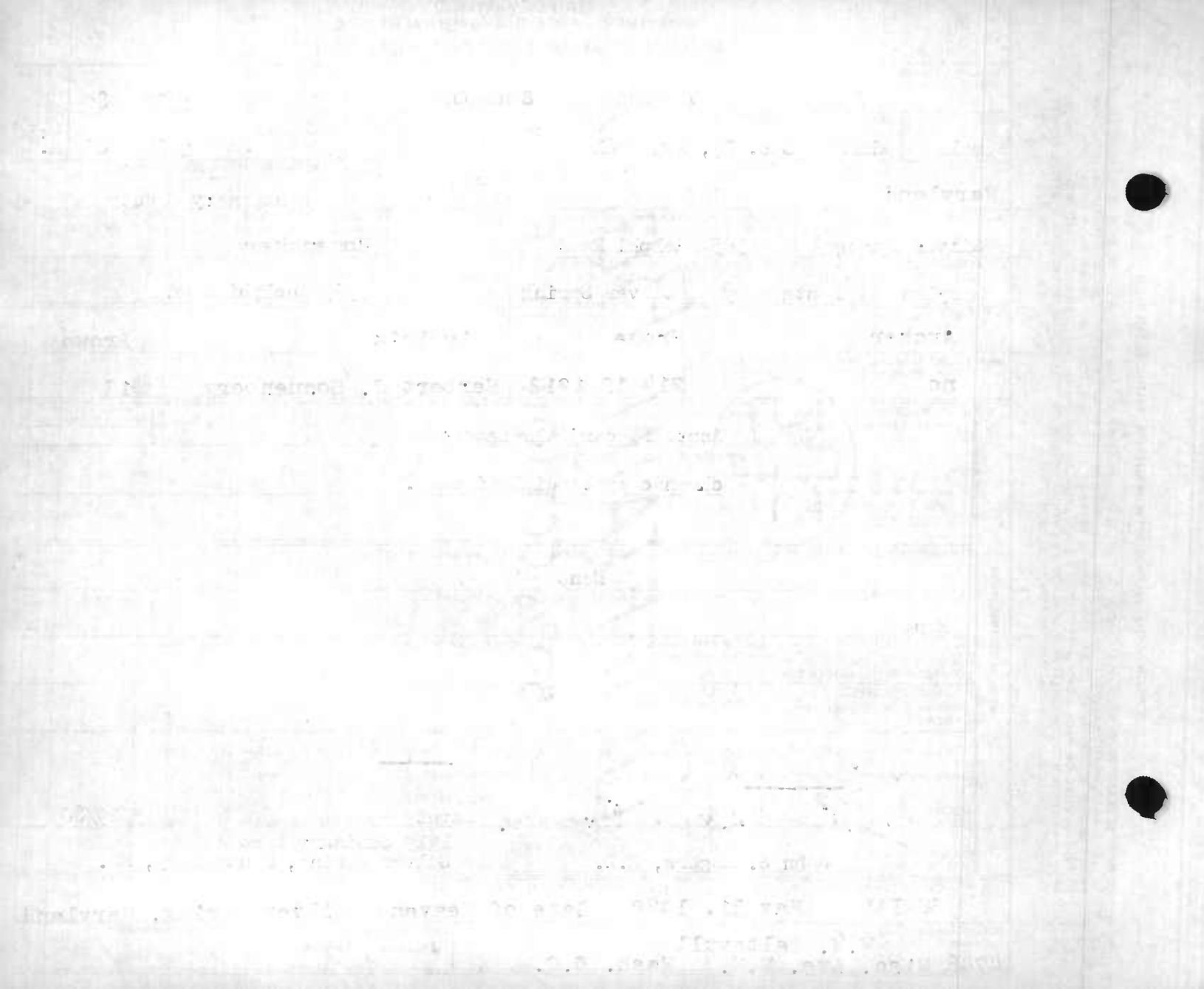
MALE  
Jm.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME(5))  
30M 7/73

| FOR<br>1- STATE REGISTRAR  |  |                           |  |   |  |  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |                                |  |                                   |  |                |  | REG. NO. 13422           |  |                          |  |
|--|--|---------------------------|--|---|--|--|--|---|--|--|--|---|--|--------------------------------|--|-----------------------------------|--|----------------|--|--------------------------|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Doris Virginia Sonnenberg   |  |                           |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>5/29 1980  |  |   |  |                                |  |                                   |  |                |  | 2b. HOUR<br>M<br>A. 4:30 |  |                          |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White          |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 29, 1918   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>61 YRS.  |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5/29 1980       |  |                                |  |                                   |  |                |  |                          |  | 2d. HOUR<br>M<br>A. 4:30 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD. |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  |                           |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>9505 Adelphi Road |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  |   |  |                                |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                |  |                          |  |                          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                           |  |   |  |  |  |   |  |  |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>9505 Adelphi Road  |  |  |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Archer Frome   |  |                           |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Virginia Brown  |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |  |                           |  | 16b. SOCIAL SECURITY NO.<br>214 12 1212   |  |  |  | 17. INFORMANT<br>Herbert J. Sonnenberg  |  |  |  |   |  |                                |  |                                   |  | ADDRESS<br>#13 |  |                          |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u><br>4291<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>chronic myocardial disease.</u><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |                           |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>None  |  |                           |  |   |  |  |  |   |  |  |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| 19a. DATE OF OPERATION<br>None   |  |                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>None   |  |  |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .  |  |                           |  |   |  |  |  |   |  | Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| ACTUAL SIGNATURE<br>   |  |                           |  | TITLE (SPECIFY)<br>Deputy MEDICAL EXAMINER  |  |  |  |   |  | DATE SIGNED<br>5/29/80   |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John S. Rogers, M.D.   |  |                           |  | ADDRESS<br>1919 Seminary Road<br>Silver Spring, Montgomery, Md.   |  |  |  |   |  |  |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |                           |  | 23b. DATE<br>May 31, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven                                 |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring, Maryland  |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W.W. Taltavull   |  |                           |  |   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 2 1980  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |                                   |  |                |  |                          |  |                          |  |
| 4748 Wisc. Ave. N.W. Wash. D.C.  |  |                           |  |   |  |  |  |   |  |  |  |   |  |                                |  |                                   |  |                |  |                          |  |                          |  |

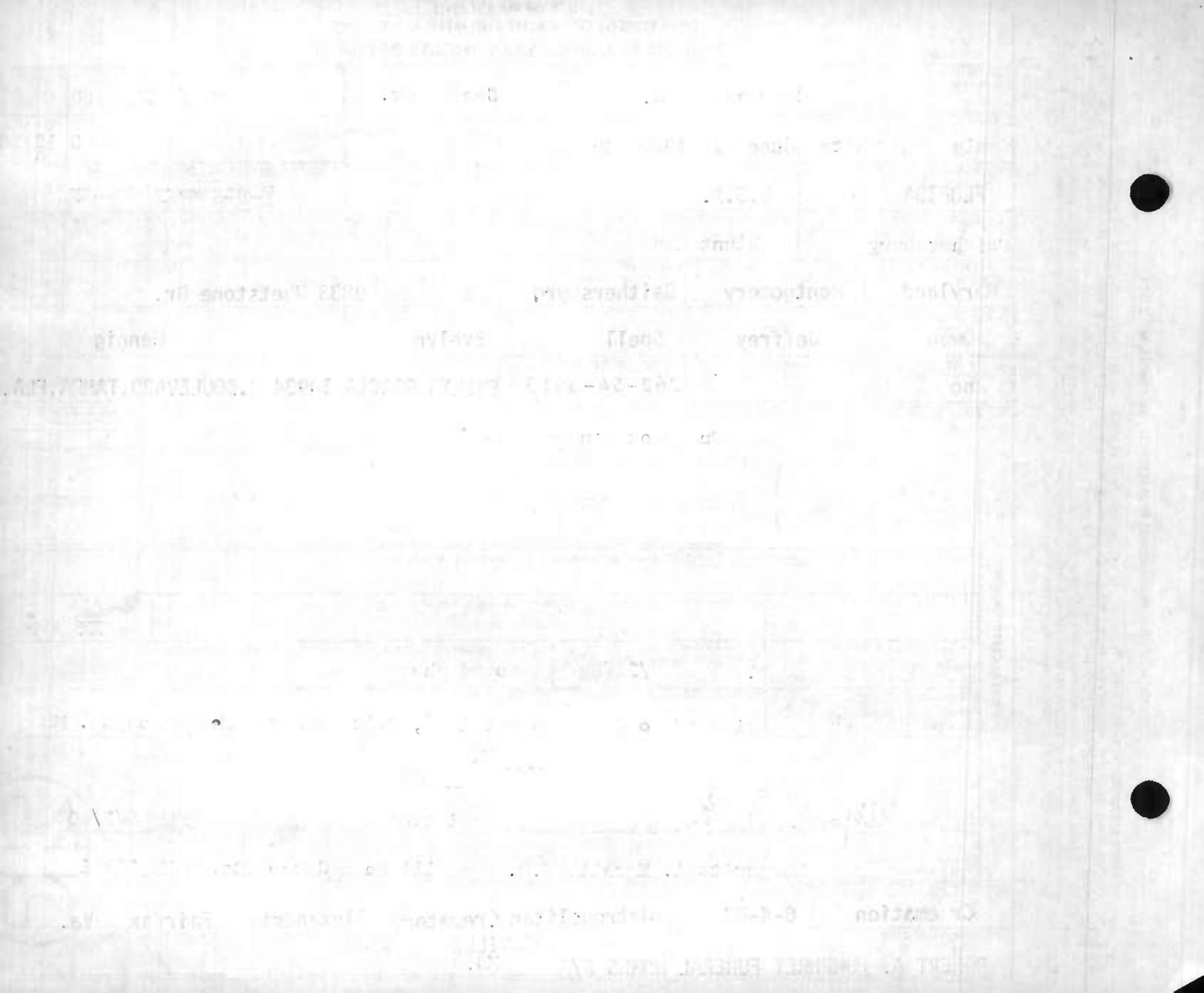




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |   |   |                  |  |  |   |  | REG. NO. 13423 |  |
|--|------------------|--|---|---|------------------|--|--|---|--|----------------|--|
| 1. FOR STATE REGISTRAR<br>1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Charles J. Spell, Sr.  |                  |  |   |   |                  | 2a. DATE OF DEATH<br>KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>5 31 1980 |  | 2b. HOUR<br>M<br>A  |  |                |  |
| 3. SEX<br>male   | 4. RACE<br>white | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 7 1940  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>39 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>6 1 1980   |  | 2d. HOUR<br>A M<br>12:30  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>FLORIDA   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.  |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Blunt Road |   |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |  |   |   |                  |  |  |   |  |                |  |
| 13a. STATE<br>Maryland   |                  | 13b. COUNTY<br>Montgomery  |   | 13c. CITY OR TOWN<br>Gaithersburg   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  | 13e. STREET ADDRESS<br>9833 Whetstone Dr.   |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Owen Jeffrey Spell   |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Evelyn Hennig  |                  |  |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>262-54-3515   |   | 17. INFORMANT ADDRESS<br>EVELYN GARCIA 10934 N. BOULEVARD, TAMPA, FLA.  |                  |  |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u><br>9654<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                  |  |   |   |                  |  |  |   |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |   |   |                  |  |  |   |  |                |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |                  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? 5/31/80 P.M.  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>found shot   |                  |  |  |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>side of road  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Blunt Road, Gaithersburg, Montgomery Co. MD  |                  |  |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |   |   |                  |  |  |   |  |                |  |
| ACTUAL SIGNATURE<br><i>Margaretha A. Korell</i>  |                  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER  |   |   |                  |  |  | DATE SIGNED<br>6/2/80   |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |                  | ADDRESS<br>111 Penn Street, Balto. MD 21201  |   |   |                  |  |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |                  | 23b. DATE<br>6-4-80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory  |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria Fairfax Va.   |  |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT A. PUMPHREY FUNERAL HOMES P/A   |                  | ADDRESS<br>ROCKVILLE MD.   |   | 25a. DATE RECEIVED BY REGISTRAR<br>JUN 5 1980   |                  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. This permit is to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RAYMOND SPENCER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 20 80</b> |   |  | 2b. HOUR<br><b>4:55 AM</b>   |  |
| 3. SEX<br><b>Male.</b>  |  | 4. RACE<br><b>White.</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 15, 1885</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery.</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BROOKE GROVE NURSING HOME</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired- Stone</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mason.</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Prince George's</b>   |   | 13c. CITY OR TOWN<br><b>Laurel</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anthony Spencer.</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown.</b>  |   | 16. STREET ADDRESS<br><b>337 Compton Ave, Laurel.</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>161-12-4673</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Dr. John R. Spencer (13 e).</b>  |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema + congestive heart failure</b> <b>few hours.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause, (a), stating the underlying cause last:<br>(b) <b>acute + chronic bronchitis</b> <b>several weeks.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Broncho-pneumonia</b> <b>1-2 weeks.</b> |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Diabetes mellitus, advanced age, generalized arteriosclerosis</b>  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>5-7-</b> <b>3-23</b> <b>1963</b> to <b>5-20</b> <b>1980</b> , that (1) (we) last saw the deceased alive on <b>5-7-</b> <b>1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated.   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>John R. Spencer</b>  |  |   |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>5-20-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |   | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>DATE<br><b>May 22, 1980</b>  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Family Plot.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Spencertown Penna.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Takoma Funeral Home</b>  |  |   |   | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 23 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

5154

• **2005**

03

10-15-2000

1990-1991

• • • • • 19-110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |                                       |  |
|--|--|---|--|--|--|---|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  | 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH                      |  |
| MEARL FREDERICK STANTON  |  | MAY 18-1980   |  | MALE   |  | CAUCASIAN   |  | AUG. 14-1922                          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 8. UNDER 1 YEAR   |  | 9. UNDER 24 HRS                       |  |
| ILLINOIS   |  | USA   |  | 57 YRS   |  | MONTHS  |  | DAYS                                  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  | 13. BALTIMORE CITY OR COUNTY OF DEATH |  |
| CHEVY CHASE  |  | 4119 STANFORD STREET  |  | PHYSICIAN  |  | MEDICAL   |  | MONTGOMERY MD                         |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                   |  |
| MARYLAND   |  | MONT.   |  | CHEVY CHASE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4119 STANFORD ST. 20015               |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)             |  | 17. INFORMANT                         |  |
| FREDERICK W. STANTON   |  | BERTHA JOHNSON  |  | YES  |  | WVTT  |  | MARGIE F. STANTON                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)                                |  | 3330  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | 3330  |  | DUE TO, OR AS A CONSEQUENCE OF        |  |
| Shye DRAGER SYNDROME   |  | DUE TO, OR AS A CONSEQUENCE OF  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | DUE TO, OR AS A CONSEQUENCE OF        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                             |  | BROCHIAL  |  | ASTHMA.  |  |   |  |                                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                       |  |
|  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.                                  |  | 1967  |  | 1967   |  | 1980  |  |                                       |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED   |  |   |  |                                       |  |
| David R. Lawrence, MD.   |  | MD.   |  | 18 May 1980  |  |   |  |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | 22f. DATE REC'D. BY REGISTRAR  |  | 22g. REGISTRAR'S SIGNATURE  |  |                                       |  |
| DAVID R. LAWRENZ   |  | 3 GRATON ST.<br>CHEVY CHASE, MD 20015   |  | MAY 21 1980  |  | E. J. McBurney  |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                                       |  |
| CREMATION  |  | 5/19/80   |  | CEDAR HILL CREM.   |  | SCITLAND, PG. MD.   |  |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 24b. ADDRESS  |  | 24c. DATE REC'D. BY REGISTRAR  |  | 24d. REGISTRAR'S SIGNATURE  |  |                                       |  |
| W. W. CHAMBERS CO.   |  | SILVER SPRING<br>MARYLAND   |  | MAY 21 1980  |  | E. J. McBurney  |  |                                       |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR

2- DATE OF DEATH MONTH DAY YEAR

3 SEX

4 RACE

5 DATE OF BIRTH MONTH DAY YEAR

6 AGE (IN YEARS LAST BIRTHDAY)

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b CITIZEN OF WHAT COUNTRY?

8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

10 CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a STATE

13b COUNTY

13c CITY OR TOWN

13d INSIDE CITY LIMITS? YES ☐ NO ☒

13e STREET ADDRESS

14. FATHER'S NAME FIRST MIDDLE LAST

15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)

17 INFORMANT ADDRESS

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES ☒ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I (this hospital) attended the deceased from May 13, 19 80, to May 20, 19 80, that I (we) last saw the deceased alive on May 20, 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death.

22b SIGNATURE DEGREE

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION CITY OR TOWN COUNTY STATE

24 FUNERAL DIRECTOR NAME ADDRESS

25a DATE REC'D. BY REGISTRAR

25b REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

pulmonary edema

DUE TO, OR AS A CONSEQUENCE OF

(b) aortic valvular stenosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Squamous cell carcinoma of tongue post operative status

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I (this hospital) attended the deceased from May 13, 19 80, to May 20, 19 80, that I (we) last saw the deceased alive on May 20, 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

22c DATE SIGNED

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

May 20, 1980

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

James F. Graves Jr., M.D.

National Naval Medical Center, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION CITY OR TOWN

COUNTY

STATE

Burial

May 22, 1980

Arlington National

Arlington

Va.

24 FUNERAL DIRECTOR NAME

ADDRESS

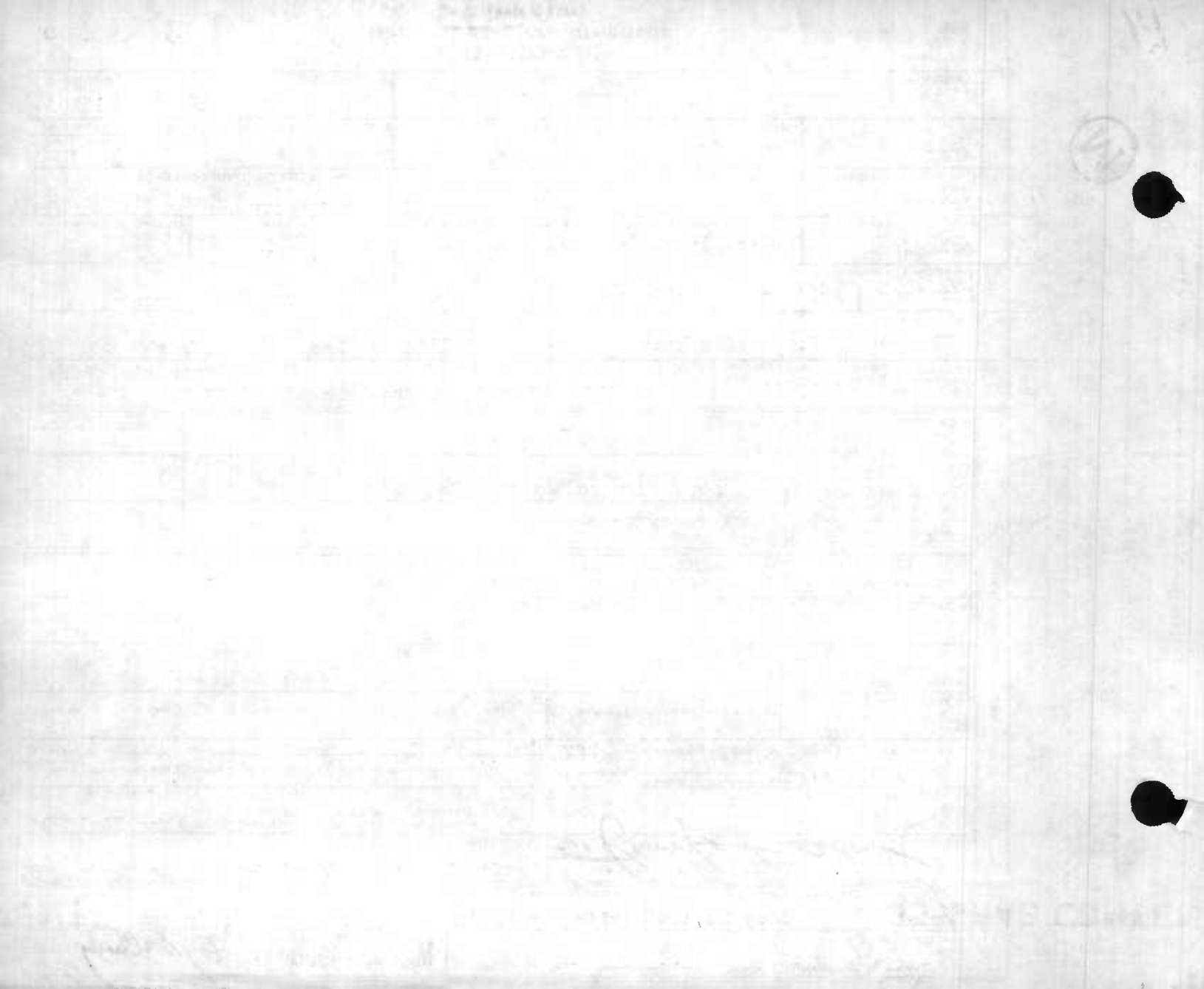
Ives Funeral Home, Arlington, Va.

25a DATE REC'D. BY REGISTRAR

25b REGISTRAR'S SIGNATURE

MAY 23 1980

[Signature]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film G546 8/23/80

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
|--|---------|---|--|---|--|---|--|--------------------------------------|--|--------------------|--|-------|------|----------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH              |  | ESTIMATED          |  | MONTH | DAY  | YEAR     | 2b. HOUR |
| JOANNE   |         |   |  |   |  | STERN   |  | 5                                    |  | 22                 |  | 19    |      | 80       |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH              |  | DAY   | YEAR | 2d. HOUR |          |
| female   | white   | Feb. 25, 1954   |  | 26 YRS.   |  |   |  | 5                                    |  | 22                 |  | 19    |      | 80       |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                    |  |       |      |          |          |
| New York   |         | USA   |  | WIDOWED   |  | DIVORCED  |  | Montgomery County                    |  |                    |  |       |      |          |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                      |  |                    |  |       |      |          |          |
| Gaithersburg   |         | Shady Grove Hospital  |  | Student   |  | School  |  |                                      |  |                    |  |       |      |          |          |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |                    |  |       |      |          |          |
| Maryland   |         | Montgomery  |  | Rockville   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 500 West Montgomery Street           |  |                    |  |       |      |          |          |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                        |  | ADDRESS            |  |       |      |          |          |
| Max  |         | Edith   |  | No  |  | 067-38-3109   |  | Max Stern                            |  | 715 S. Winton Road |  |       |      |          |          |
|  |         |   |  | N/A   |  |   |  |                                      |  | Rochester, N.Y.    |  |       |      |          |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| PART 1 DEATH WAS CAUSED BY:  |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| IMMEDIATE CAUSE (a) <u>Asphyxia</u>  |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| (b) <u>Airway occlusion</u>  |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| (c)  |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| <u>Schizophrenia</u>   |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
|  |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |                                      |  |                    |  |       |      |          |          |
|  |         | 2:45 P.M. 5/22/ 19 80                                       |  | Subject placed plastic bag over head  |  |   |  |                                      |  |                    |  |       |      |          |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  |   |  |                                      |  |                    |  |       |      |          |          |
|  |         | Bldg.   |  | 500 W. Montgomery Ave. Rockville Montg. Co. Md.                               |  |   |  |                                      |  |                    |  |       |      |          |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |  | MEDICAL EXAMINER  |  | DATE SIGNED   |  |                                      |  |                    |  |       |      |          |          |
|  |         | Assistant   |  |   |  | 5-23-80   |  |                                      |  |                    |  |       |      |          |          |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| Ann M. Dixon, M.D.   |         | 111 Penn St.  |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |                                      |  |                    |  |       |      |          |          |
| Burial   |         | 5-27-80   |  | Mt. Hope  |  | Rochester, Monroe, New York   |  |                                      |  |                    |  |       |      |          |          |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                                      |  |                    |  |       |      |          |          |
| NAME   |         | ADDRESS   |  | MAY 28 1980   |  |   |  |                                      |  |                    |  |       |      |          |          |
| DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.   |         |   |  |   |  |   |  |                                      |  |                    |  |       |      |          |          |

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR

NAME

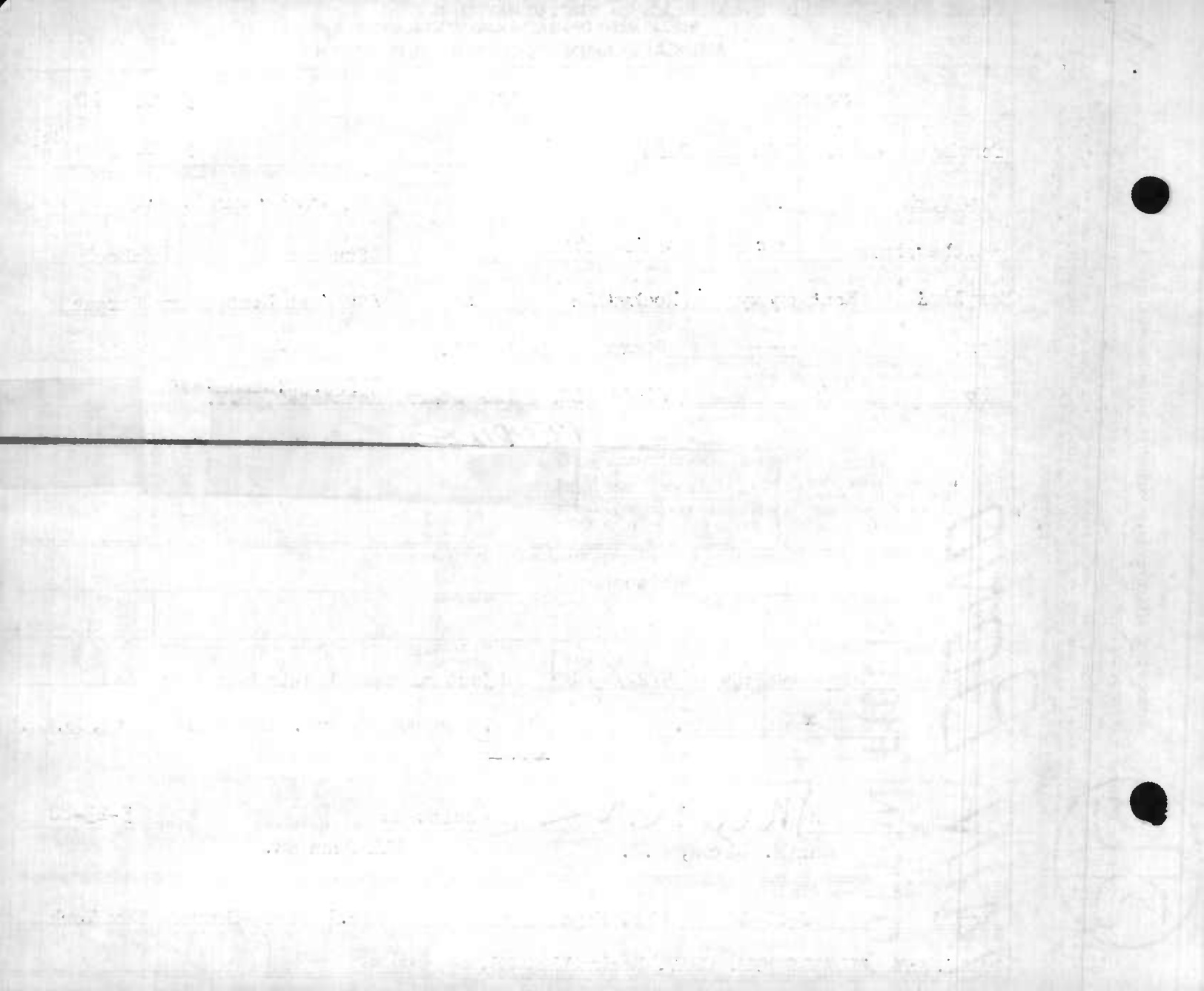
ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.

MAY 28 1980



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 1 3 4 2 8   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Charles H. Stewart</i>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>May 3 80</i>   |  | 2b. HOUR<br><i>6 50 A M</i>   |  |
| 3. SEX<br><i>male</i>  |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>July 24 1916</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><i>63</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery City MD.</i>  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>LABORER</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>STATE RD.</i>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN<br><i>Maryland Mont. City Gaithersburg</i>   |  |  |  | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13f. STREET ADDRESS<br><i>18381 Leontine # 102</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>HENRY STEWART</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>IRENE MOORE</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>NO</i>   |  | 16b. SOCIAL SECURITY NO<br><i>220-07-8374</i>  |  | 17. INFORMANT ADDRESS<br><i>Dorothy Stewart (wife) SAME AS #13</i>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>BRONCHO PNEUMONIA - sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 DAY</i>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>APRIL 4 1980</i> to <i>MAY 3 1980</i> , that (I) (we) saw the deceased alive on <i>MAY 3 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |  |  |   |  |   |  |
| 22b. SIGNATURE <i>Walter E. Goetz MD</i> DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><i>MAY 5, 1980</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>WALTER E. GOETZ MD</i>   |  |  |  | 22e. ADDRESS<br><i>2309 SHOREFIELD RD WHEATON MD</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>5-7-80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Rose of Lima</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Gaithersburg Mont. Md.</i>  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>George R. Snowden</i>  |  |  |  | 24b. ADDRESS<br><i>246 N. WASH. ST. ROCKVILLE, MD.</i>  |  | 25. PREPARED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

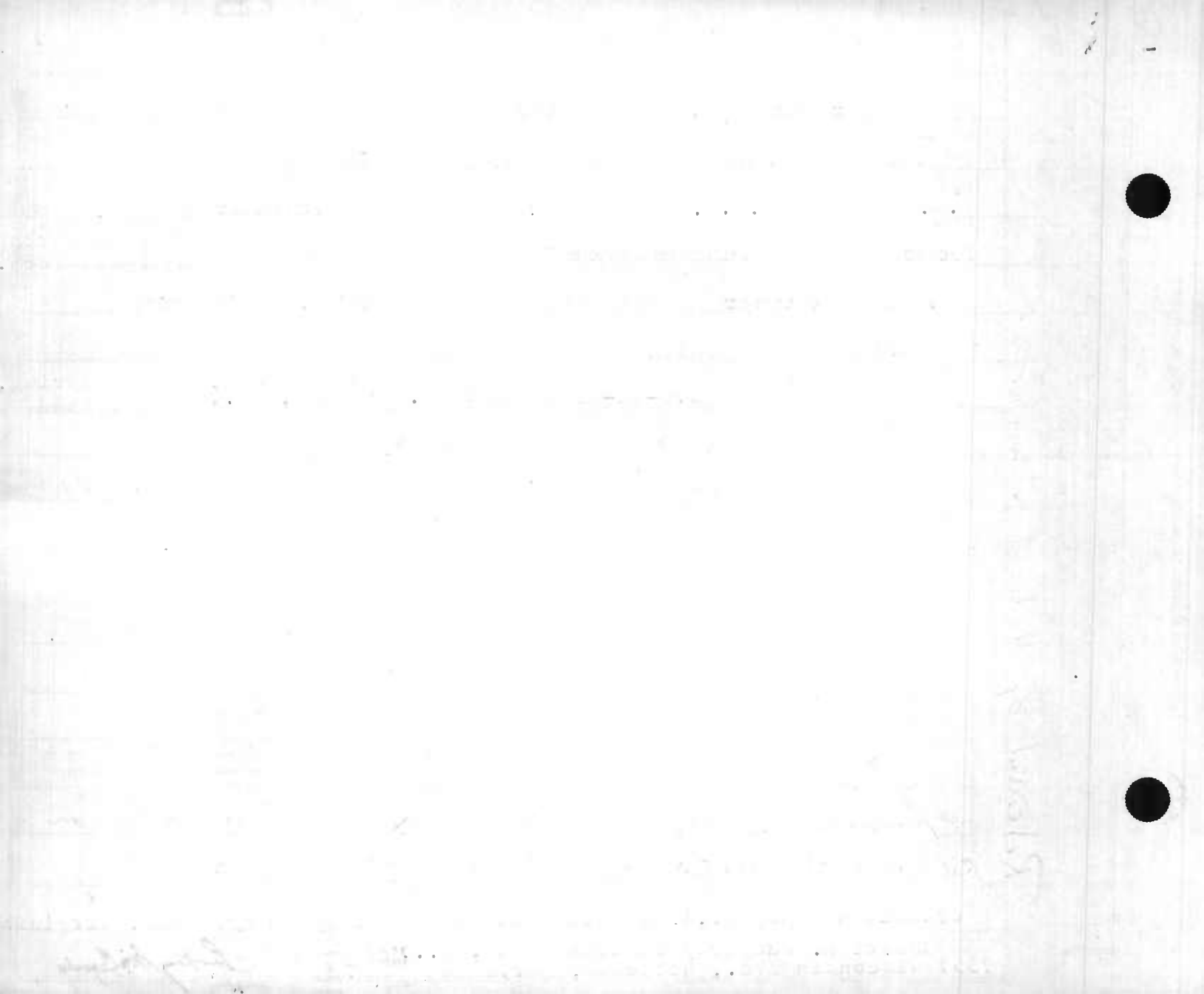
IMPORTANT: If item 21 is marked pr. item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Medical Examiner

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |                                 |  |   |  |
|---|--|--|--|---|--|--|---------------------------------|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 8 0 1 3 4 2 9  |  |   |  | REG. NO.   |                                 |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret S. Stimson  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 16, 1980              |  |                                 | 2b. HOUR<br>2:17AM   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 19, 1904   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS  |                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.   |                                 |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Librarian  |                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Research Analysis Corp.   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |  |  |   | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Kensington |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown Smith   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillian Unknown |  |                                 |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO<br>579-42-6503   |  | 17. INFORMANT<br>ADDRESS<br>8323 Draper Lane, Silver Spring, Maryland<br>Richard D. Stimson, Jr.,   |  |  |                                 |  |   |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>4140</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic HEART DISEASE</u><br>5 YRS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 HRS</u> |  |  |  |   |  |  |                                 |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |   |  |  |                                 |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                                 |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                 |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>about</u> 19 <u>75</u> to <u>5-16</u> 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>5-16</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.            |  |  |  |   |  |  |                                 |  |   |  |
| 22b. SIGNATURE<br>Richard H. Pollen   |  | DEGREE<br>MD   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                 | 22c. DATE SIGNED<br>5-16-80  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD H. POLLEN MD   |  |  |  | 22e. ADDRESS<br>KENSINGTON MD 20795   |  |  |                                 |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>May 17, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crematory  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria, Virginia   |                                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME Robert A. Pumphrey   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 21 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>R. H. Pollen   |                                 |  |   |  |
| 7557 Wisconsin Ave., Bethesda, Maryland   |  |  |  |   |  |  |                                 |  |   |  |





BH

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH80 13430  
REG. NO.

|   |  |   |  |  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|--|--|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARIAN TISSOT STRAUBE</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 5, 1980</b> |  |  | 2b HOUR<br><b>7:30<sup>PM</sup></b>   |  |   |  |   |  |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOVEMBER 18, 1922</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.  |  | 7a IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>57</b>                                      |  | 7b IF UNDER 24 HRS<br>HOURS MIN.<br><b>57</b>   |  |  |  |
| 7c BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Oregon</b>   |  | 7d CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY County, MD.</b>                        |  |   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BETHESDA</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE CLINICAL CENTER</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dietitian</b>         |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>                                 |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>   |  |   |  |  |  | 13b COUNTY<br><b>Montgomery</b>   |  | 13c CITY OR TOWN<br><b>BETHESDA</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e STREET ADDRESS<br><b>4517 GRETNA ST. 20014</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence Tissot</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Grace Euvarde</b>  |  |   |  |   |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |  | 16b SOCIAL SECURITY NO.<br><b>356-40-7006</b>  |  | 17 INFORMANT<br><b>DR. ROBERT STRAUBE (NOK)</b>   |  |   |  | ADDRESS<br><b>SAME AS ABOVE</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Respiratory insufficiency, etiology unknown</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Progressive Ovarian carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1830</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |   |  |   |  |  |  |
| 19a DATE OF OPERATION   |  |   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |  |  |
| 22a I certify that (H) (this hospital) attended the deceased from <b>APRIL 7, 1980</b> to <b>may 5, 1980</b> , that (we) lost<br>saw the deceased alive on <b>MAY 5, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (H) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |   |  |   |  |  |  |
| 22b SIGNATURE<br><b>Byron H. Chesbro</b> M.D.   |  |   |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>5/6/80</b>   |  |   |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BYRON H. CHESBRO</b>   |  |   |  |  |  | 22e ADDRESS<br><b>NATIONAL INSTITUTES OF HEALTH<br/>CLINICAL CENTER, BETHESDA, MARYLAND</b> |  |   |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |   |  | 23b DATE<br><b>May 9, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan</b>                                   |  |   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria, Virginia</b>  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>ROBERT A. PUMPHREY FUNERAL<br/>HOMES, P.A., BETHESDA, MARYLAND</b>  |  |   |  |  |  | 25a DATE BY REGISTRAR<br><b>MAY 10 1980</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5858.



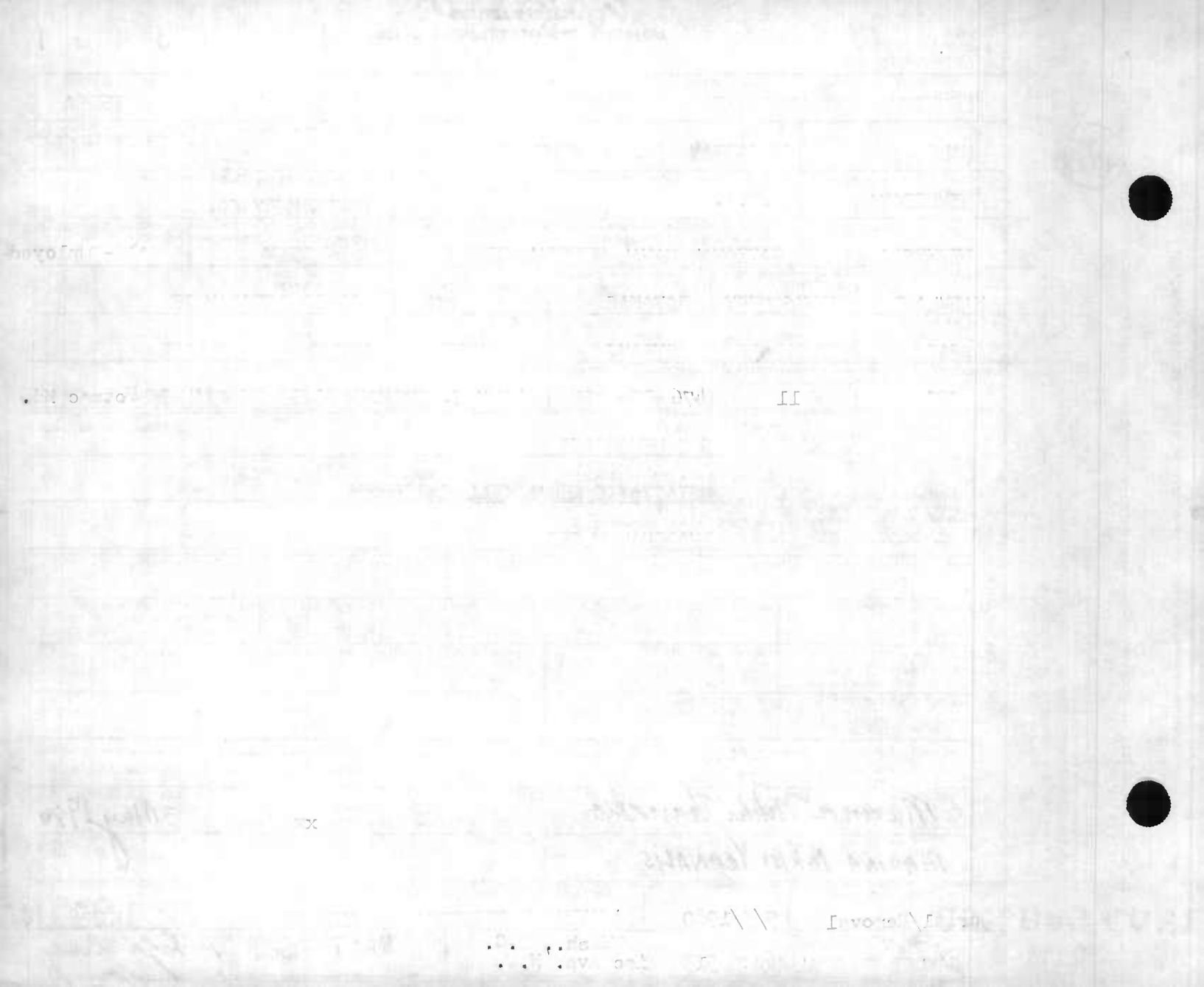
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 8013431   |  | REG. NO.  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>KENNETH THEODORE STRAUCH  |  |   |  | 2a. DATE OF DEATH<br>MAY 03 1980  |  | 2b. HOUR<br>0300A M   |  |   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>JUNE 07 <sup>th</sup> 1924  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MINNESOTA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY CO. MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NATIONAL NAVAL MEDICAL CENTER |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DENTIST                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Employed  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>MONTGOMERY   |  | 13c. CITY OR TOWN<br>POTOMAC  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>11511 DEBORAH DR   |  |
| 14. FATHER'S NAME<br>OSCAR THEODORE STRAUCH   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>SADIE SOPHIE RUMMEL   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>WW11 476-20-8484  |  | 17. INFORMANT ADDRESS<br>MARY J. STRAUCH 11511 DEBORAH DR Potmac Md.  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>G I HEMORRAGE</u><br><u>1890</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC RENAL CELL CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>DUODENAL ULCER</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1458 02 MAY 1980</u> to <u>0300 03 MAY 1980</u> , that (I) (we) last saw the deceased alive on <u>03 MAY 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Marina Nikki Vernalis</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>3 May 1980</u>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MARINA NIKKI VERNALIS</u>   |  |   |  | 22e. ADDRESS  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial/Removal</u>  |  | 23b. DATE<br><u>5/5/1980</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>LAKE SIDE CEMETERY</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>AITKIN MINN</u>                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>GAWLER FUNERAL HOME</u>  |  |   |  | ADDRESS<br><u>Wash., D.C. 5130 Wisc Ave. N.W.</u>   |  | 25a. DATED BY REGISTRAR<br><u>MAY 7 1980</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCready</u>   |  |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

13432

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY A LAST STRICKLAND   |   |   | 2a. DATE OF DEATH<br>MONTH MAY DAY 22 YEAR 1980   |  | 2b. HOUR<br>1242P  |
| 3. SEX<br>F   | 4. RACE<br>BLACK  | 5. DATE OF BIRTH<br>MONTH APRIL DAY 4 YEAR 1917   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Takoma Park  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Washington Adventist |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None                      |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE Maryland 13c. COUNTY Montgomery 13d. CITY OR TOWN Takoma Park  |   |   | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST James MIDDLE LAST Austin   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST Martha MIDDLE STOCKES   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>061-16-9739   |   | 16c. MIDDLE INITIAL<br>MILLARD STRICKLAND<br>MARTHA STRICKLAND                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>496-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Respiratory failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>Chronic obstructive Pulmonary</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.<br><u>arteriosclerotic heart disease, congestive heart failure</u> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I), (this hospital) attended the deceased from <u>4-26</u> , 19 <u>80</u> , to <u>5-22</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>5-22</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><u>M Snow M.D.</u>  |   | DEGREE  |   | 22c. DATE SIGNED<br>5.22.80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M SNOW MD  |   | 22e. ADDRESS<br>9013 FLOWER AVE SILVER SPRING MD 20901  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |   | 23b. DATE<br>5/28/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Maryland  |   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME LATNEY's Funeral Home Wash. DC   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 2 1980   |   | 25b. REGISTRAR'S SIGNATURE<br>Rickey Halverson                                       |  |

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8013433  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 1. DECEASED NAME FIRST MIDDLE LAST<br><b>John Cornelius Sullivan</b>  |  |   |  |
| 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5-17-80</b>   |  | 2b. HOUR<br><b>7:04 A.M.</b>   |  | 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cauc.</b>   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 25, 1917</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>63</b>   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash., D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  | 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wash. Adventist Hospital</b> |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Trucking</b>   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN<br><b>Maryland Anne Arundel Gambrills</b> |  | 13e. STREET ADDRESS<br><b>1597 Defense Highway</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Michael Sullivan</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Katie Louise Marlow</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>yes WW II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>579-05-0500</b>  |  |
| 17. INFORMANT<br><b>Katherine B. Sullivan Gambrills, Md.</b>   |  | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br><b>1629 respiratory failure</b><br>IMMEDIATE CAUSE (a) <b>with status epilepticus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>DUE TO, OR AS A CONSEQUENCE OF:<br>DUE TO, OR AS A CONSEQUENCE OF:<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>576</b> 19 <b>80</b> , to <b>577</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>Lewis H. Dennis, M.D.</b>   |  | 22c. ADDRESS<br><b>831 University Blvd.E., Maryland</b>   |  | 22d. DATE SIGNED<br><b>5/17/80</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>May 20, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Vet. Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Cheltenham, Maryland</b>  |  |
| 24a. FUNERAL DIRECTOR<br><b>Robert G. Beall Funeral Home</b>   |  | 24b. ADDRESS<br><b>16000 Annapolis Rd., Bowie, Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 23 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

Silver Spring

631 University Blvd.E., Maryland

Lewis H. Dennis, M.D.

May 20, 1980 M. Vet. Cemetery Cheltenham, Maryland

Robert G. Beall Funeral Home  
1000 Annapolis Rd., Bowie, Maryland  
410-328-1280

*[Handwritten signature]*

Yes      WW II      279-02-0200 Katherine B. Sullivan Gambrills, Md.  
1597 Defense Highway      Louise      Marlow

Michael      Sullivan      Katie      1597 Defense Highway  
Maryland Anne Arundel Gambrills x

Takoma Park Wash. Adventist Hospital      Truck Driver      Trucking  
Wash., D.C.      U.S.A.      Montgomery

Male      Educ.      March 22, 1917      63

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | REG. NO.   |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)<br><b>Mary J. TALBOTT</b>  |  |   |  | 2a. DATE OF DEATH<br><b>May 14, 1980</b>   |  |  |  | 2b. HOUR<br><b>9:00 P.M.</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 16, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery Co., MD.</b>                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Gaithersburg</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>16 S. Frederick Ave., Apt. 206</b>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John H. Snouffer</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia McKindless</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>577-01-0720</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Helen Ward, 102 Floral Dr. Gaithersburg, Md.</b>      |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a): <b>Cardiomyopathy Atherosclerosis</b><br><b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF,<br>(b) <b>Abnormal Heart Function - CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF,<br>(c) <b>Post-Surgical CARDIOMYOPATHY STOMACH</b> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 HOURS</b><br><b>3 YEARS</b><br><b>6 DAYS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>SICK SINUS SYNDROME</b>  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>MAY 9 1980</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CANCER STOMACH</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUN 19 76</b> to <b>MAY 14 80</b> , that (I) (we) lost<br>saw the deceased alive on <b>MAY 14 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Gregorio Lopez</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>5/14/80</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gregorio Lopez MD</b>   |  |   |  | 22e. ADDRESS<br><b>11125 KORMAN DR. POTOMAC - MD 20854</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 17, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Monocacy</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Beallsville, Mont. Md.</b>          |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Olin L. Molesworth, Damascus, Md.</b>  |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 20 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |  |  |  |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |   |  |  |  |   |  | REG. NO. 13435   |  |
|--|--|----------------------|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Warren Lilly Talley</b>   |  |                      |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <b>May 17, 1980</b>   |  | 2b. MONTH DAY YEAR <b>May 17, 1980</b>   |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b> |  | 5. DATE OF BIRTH <b>NOV. 16, 1922</b>   |  | 6. AGE IN YEARS <b>57</b> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD <b>May 17, 1980</b>                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Takoma Park</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>West Advent Hosp</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>  |  |   |  | 12b. KIND OF BUSINESS <b>Remington Rand Co.</b>                                  |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  |   |  | 13b. COUNTY <b>Prince Georges</b>                                     |  | 13c. CITY OR TOWN <b>Hyattsville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1430 University Blvd.</b> |  |  |  |
| 14. FATHER'S NAME <b>Robert Talley</b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME <b>Lillie Bryant</b>                         |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>WW 11 579 14 3722</b>   |  | 17. INFORMANT <b>Ruth P. Talley</b> ADDRESS <b>Same as #13 (Wife)</b> |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b><br>4291<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Chronic Myocardial Dis.</b><br>(c) <b>Yr.</b>  |  |                      |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>Cirrhosis of Liver with Ascites</b>  |  |                      |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |  |                      |  | TITLE (SPECIFY) <b>M.D.</b>   |  |   |  | MEDICAL EXAMINER   |  |   |  | DATE SIGNED <b>May 17, 1980</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>  |  |                      |  | ADDRESS <b>1919 Seminary Rd. Silver Spring, Md.</b>   |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>5/20/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>        |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b>  |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 20 1980</b>                      |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Dickie Melby</b>  |  |  |  |

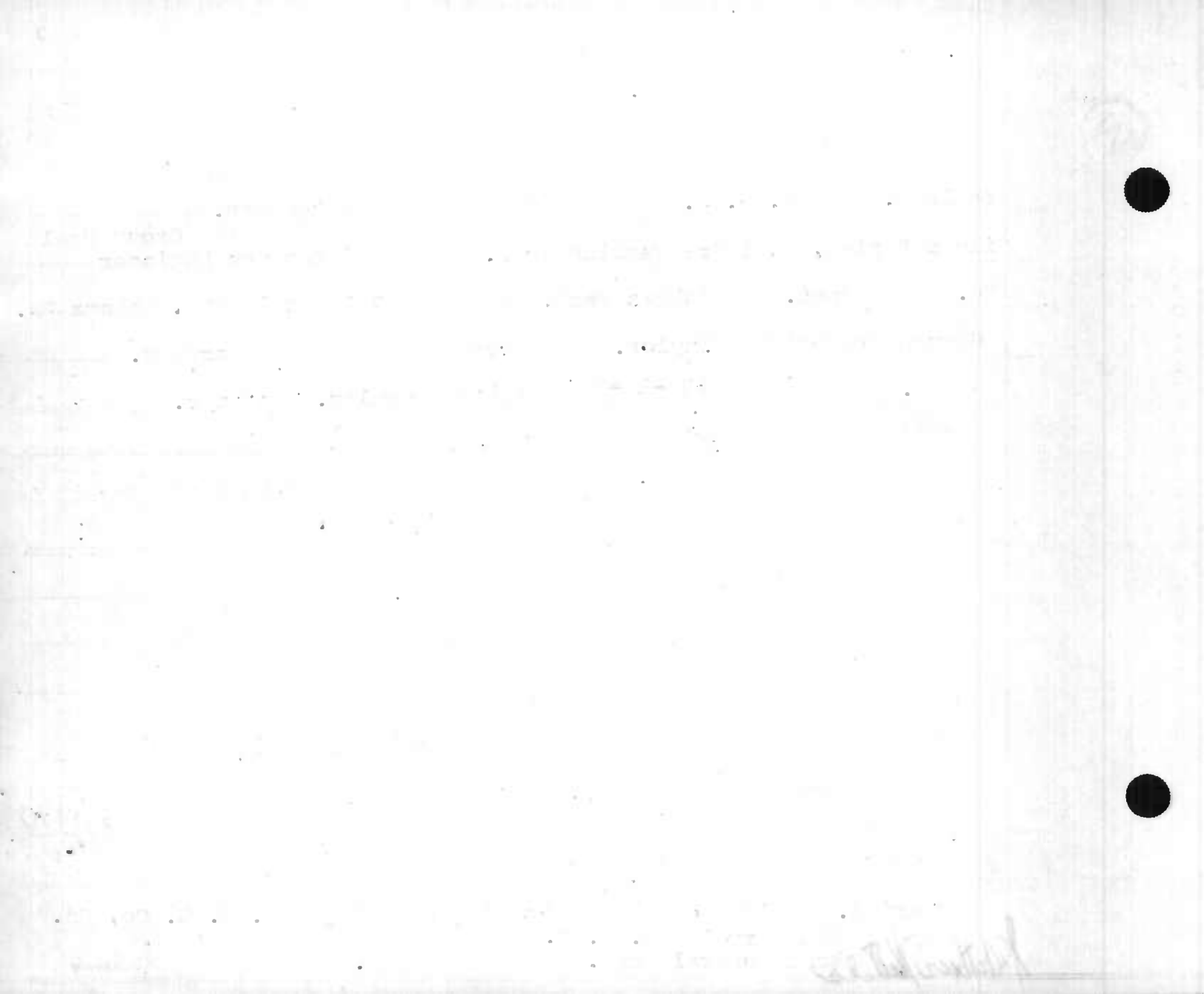


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death is not reported to the health department, the certificate should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8013436  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>FREDERICK G. Taylor</b>  |  |  |  | 2b. HOUR<br><b>9<sup>30</sup> P.M.</b>  |  |  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 1 99</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>England.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery.</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring,</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bel Pre Nursing Home.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance Engineer</b>  |  | 12b. KIND OF BUSINESS OR<br><b>Group Health</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |  |  | 13b. COUNTY<br><b>Mont.</b>   |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Frederick Taylor.</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Laura Gardner.</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No.</b>   |  |  |  | 16b. SOCIAL SECURITY NO<br><b>579-14-3905</b>   |  | 17. INFORMANT ADDRESS<br><b>Winifred Fowler. Daughter.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Coma Fever.</b><br><b>436-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Chronic Brain Syndrome / Cerebral arteriosclerosis</b><br>(c) <b>and Stroke.</b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/11/59</b> to <b>5/22/80</b> , that (I) (we) last saw the deceased alive on <b>5/16/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Hamid Montakhab MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>5/23/1980</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAMID MONTAKHAB, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>6111 Executive Blvd. Rockville MD 20852</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial.</b>   |  | 23b. DATE<br><b>May 27, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>George Washington</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Riggs Rd. P. G. Co, Md.</b>   |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>254 Carroll St. N. W.</b>   |  |  |  | 24b. ADDRESS<br><b>Takoma Funeral Home.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 26 1980</b>  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McElroy</b>   |  |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

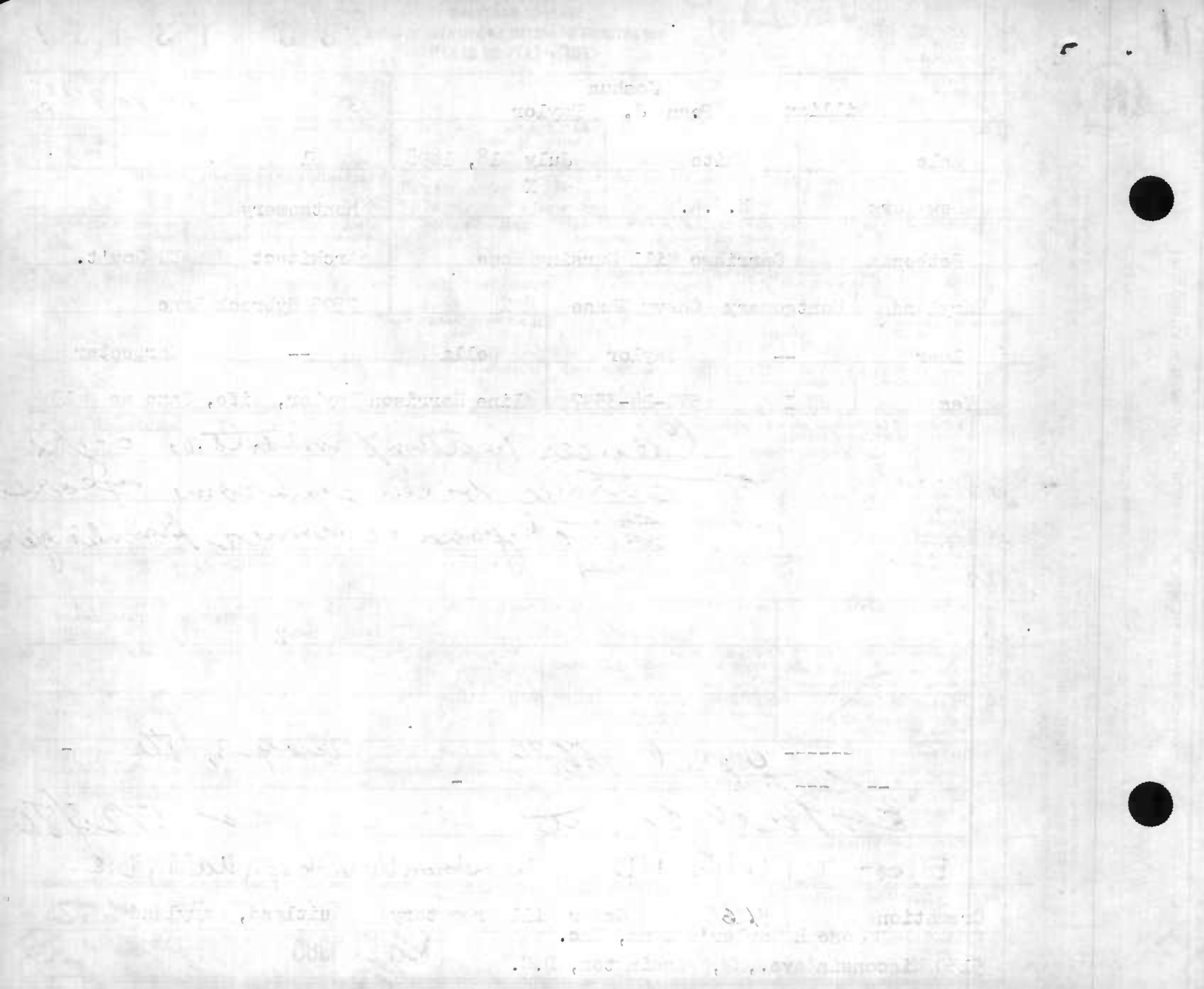
8013437

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |  |   |   |
|---|---|--|--|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William Penn Taylor  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>5 - 23-80                              |   | 2b HOUR<br>9:25 PM  |
| 3 SEX<br>Male   | 4 RACE<br>White   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>July 18, 1898   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS                                     | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                        |   |   |
| 10 CITY OR TOWN OF DEATH<br>Bethesda  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Carriage Hill Nursing Home |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Architect | 12b KIND OF BUSINESS OR INDUSTRY<br>US Gov't.                                       |   |
| 13a STATE<br>Maryland   |   |  | 13b COUNTY<br>Montgomery   | 13c CITY OR TOWN<br>Chevy Chase   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elmer Taylor   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Della Carpenter             |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |   | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>WW I 579-24-3597  |  | 17 INFORMANT<br>ADDRESS<br>Aline Harrison Taylor, Wife, Same as # 13                |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cancer rectum &amp; metastases</u> 6 yrs<br>1541<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Chronic brain syndrome</u> years<br>(c) <u>Emphysema &amp; chronic bronchitis</u> years<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |  |   |   |
| 19a DATE OF OPERATION   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a I certify that (I) (this hospital) attended the deceased from <u>April 1980</u> to <u>May 23, 1980</u> , that (I) (we) lost<br>saw the deceased alive on <u>April 1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |   |  |  |   |   |
| 22b SIGNATURE<br><u>E. Phelps, MD</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c DATE SIGNED<br><u>5/23/80</u>   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elbert T Phelps MD  |   | 22e ADDRESS<br>Corgetown Univ. Hosp., Wash., D.C.  |  |   |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  | 23b DATE<br>5/26/80   | 23c NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Maryland                     |   |
| 24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.<br>NAME ADDRESS<br>5130 Wisconsin Ave., NW, Washington, D.C.   |   |  | 25a DATE REC'D BY REGISTRAR<br>MAY 29 1980                                   |   | 25b REGISTRAR'S SIGNATURE<br><u>Marjorie M. ...</u>   |

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Item #17 per phone call w/Fun. <b>DEPARTMENT OF HEALTH AND MENTAL HYGIENE</b><br><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>  |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
|--|--|-------------|--|---|--|---|--|--|--|---|--|---|--|-----------|--|-----------|--|----------------------------|--|----------|--|--|--|----------------------------|--|--|--|--|--|-------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST       |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH  |  | <input checked="" type="checkbox"/> MONTH<br><input type="checkbox"/> ESTIMATED |  | DAY   |  | YEAR      |  | 2b. HOUR  |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| WILLIAM  |  | Russell     |  | Thickstun   |  |   |  | 5  |  | 24  |  | 19  |  | 80        |  | 12:15 P M |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 3. SEX   |  | 4. RACE     |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 24 YRS.  |  | 8. IF UNDER 24 HRS.   |  | 9. DATE PRONOUNCED DEAD   |  | 10. MONTH |  | DAY       |  | YEAR                       |  | 2b. HOUR |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| male   |  | white       |  | Aug 20 1899   |  | 80 YRS.   |  |  |  |   |  | 5   |  | 24        |  | 19        |  | 80                         |  | P M      |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |             |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| Kentucky   |  |             |  | U.S.A.  |  |   |  |  |  |   |  | Montgomery County MD.   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |             |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| Bethesda   |  |             |  | Suburban Hospital   |  |   |  | Weather Bureau U.S. Gov't  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| Md.  |  | Montgomery  |  | Bethesda  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 7803 Marbury Road  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 14. FATHER'S NAME  |  |             |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| FIRST  |  | MIDDLE      |  | LAST  |  | FIRST   |  | MIDDLE   |  | LAST  |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| John   |  | William     |  | Thickstun   |  | Grace   |  |  |  |   |  |   |  |           |  | Bell      |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |             |  |   |  | 16b. SOCIAL SECURITY NO.  |  |  |  |   |  | 17. INFORMANT ADDRESS   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| No   |  |             |  |   |  | 220-44-4279   |  |  |  |   |  | William R. Thickstun, Jr.<br>#5 Wellings Drive, Potsdam, N.Y.                 |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Abdominal injuries</u>  |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| (b)  |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| (c)  |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |             |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |  |  |   |  | 20. AUTOPSY?  |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
|  |  |             |  |   |  |   |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |             |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 11:10AM 5-24 1980  |  |             |  |   |  | driver of auto/auto impact  |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |             |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)         |  |  |  |   |  | 21f. LOCATION   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| street   |  |             |  |   |  | Viers Mill Dr. at Parklawn Dr., Rockville, Md.                      |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |             |  |   |  |   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| ACTUAL SIGNATURE   |  |             |  |   |  | TITLE (SPECIFY)   |  |  |  |   |  | DATE SIGNED   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| Margarita A. Korell, M.D.  |  |             |  |   |  | M.D. Assistant  |  |  |  |   |  | 5-25-80   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |             |  |   |  | ADDRESS   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| Margarita A. Korell, M.D.  |  |             |  |   |  | 111 Penn Street   |  |  |  |   |  |   |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |             |  |   |  | 23b. DATE   |  |  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |           |  |           |  | 23d. LOCATION CITY OR TOWN |  |          |  |  |  | COUNTY                     |  |  |  |  |  | STATE |  |  |  |  |  |
| BURIAL   |  |             |  |   |  | 5-30-80   |  |  |  |   |  | Parklawn Mem. Park  |  |           |  |           |  | Rockville                  |  |          |  |  |  | Md.                        |  |  |  |  |  |       |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |             |  |   |  |   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |           |  |           |  |                            |  |          |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |  |       |  |  |  |  |  |
| Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland   |  |             |  |   |  |   |  |  |  |   |  | JUN 3 1980  |  |           |  |           |  |                            |  |          |  |  |  |                            |  |  |  |  |  |       |  |  |  |  |  |



THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

RECEIVED

APRIL 10 1954

FROM

TO

BY

DATE

REMARKS

1. The sample was received from the laboratory of Dr. J. H. Dole, University of California, Berkeley, California. The sample was a white, crystalline solid, melting at 100°C. The sample was analyzed for carbon, hydrogen, and nitrogen, and the results are given in the table below.

2. The sample was found to be pure, and the results of the analysis are in good agreement with the theoretical values for the compound.

3. The sample was found to be stable in air, and no significant weight loss was observed during the analysis.

4. The sample was found to be soluble in a variety of organic solvents, including benzene, chloroform, and carbon tetrachloride.

5. The sample was found to be stable in water, and no significant weight loss was observed during the analysis.

6. The sample was found to be stable in acid, and no significant weight loss was observed during the analysis.

7. The sample was found to be stable in alkali, and no significant weight loss was observed during the analysis.

8. The sample was found to be stable in oxidizing agents, and no significant weight loss was observed during the analysis.

9. The sample was found to be stable in reducing agents, and no significant weight loss was observed during the analysis.

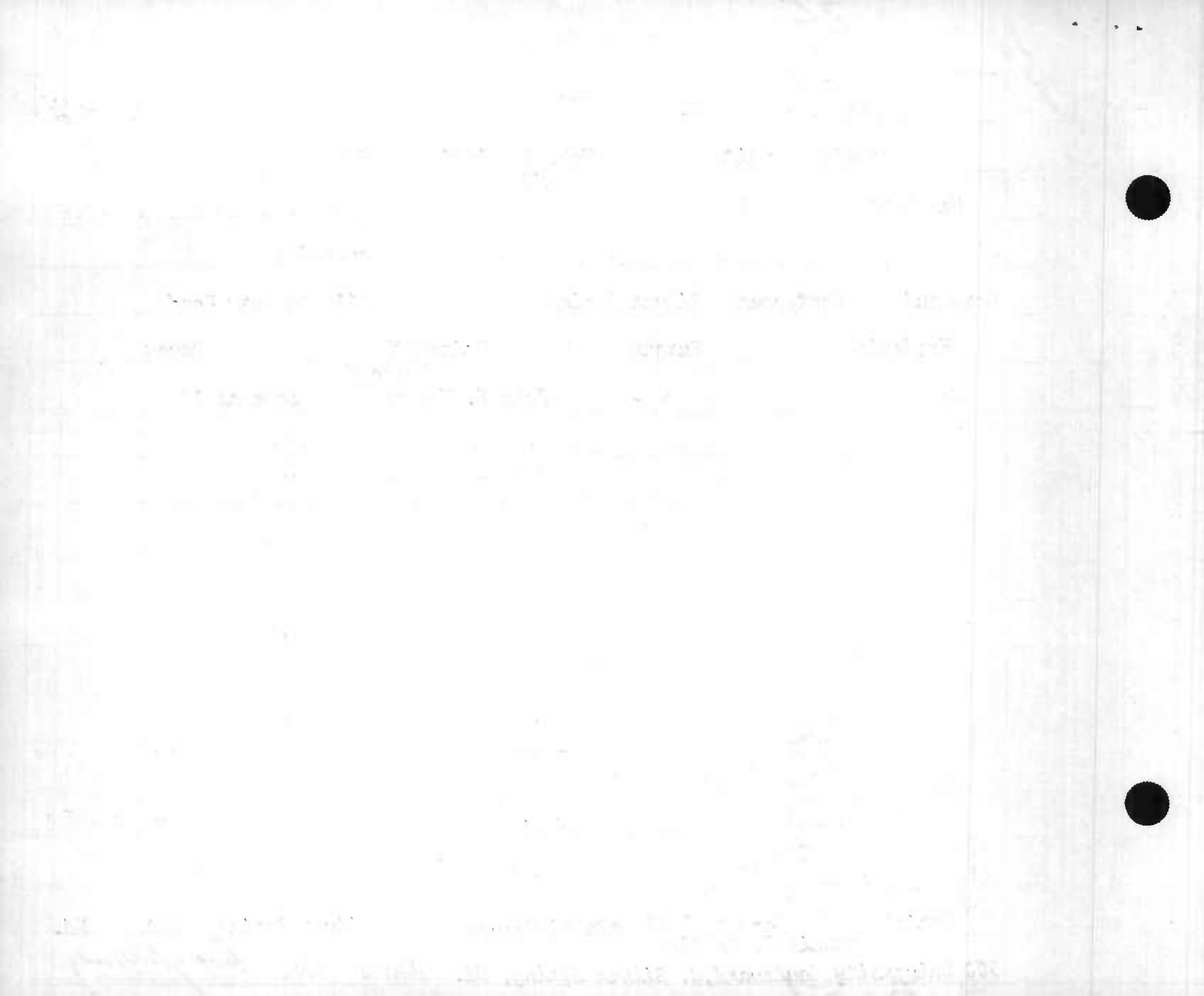
10. The sample was found to be stable in all other reagents tested, and no significant weight loss was observed during the analysis.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |  |  | 8  | 0 | 1                                  | 3 | 4  | 3 | 9  |  |
|--|--|---|--|---|--|--|--|--|--|--|---|------------------------------------|---|--|---|--|--|
| FOR STATE REGISTRAR  |  |   |  |   |  |  |  |  |  | REG. NO.   |   |                                    |   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Catherine H. Thomas  |  |   |  |   |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>5 2 80  |   |                                    |   | 2b. HOUR<br>5 15 AM  |   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 24, 1902   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN.      |   |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY COUNTY MD.              |  |  |  |  |   |                                    |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>SILVER SPRING   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLY CROSS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |                                    |   |  |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   |  |   |  |  |  |  |  | 13b. COUNTY<br>Montgomery  |   | 13c. CITY OR TOWN<br>Silver Spring |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>9119 Sudbury Road |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick Burgun   |  |   |  |   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Havey   |   |                                    |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |  | 17. INFORMANT<br>husband<br>John F. Thomas                                 |  |  |  | ADDRESS<br>same as 13  |   |                                    |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardio-vascular Collapse, Kidney Failure</u><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>advanced intestinal obstruction</u><br>(c) <u>metastatic cancer of colon &amp; liver, etc</u> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |                                    |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |  |  |  |   |                                    |   |  |   |  |  |
| 19a. DATE OF OPERATION<br>5-1-80   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>intestinal obstruction  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                    |   |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>—  |  |  |   |                                    |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |                                    |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-29</u> 19 <u>80</u> , to <u>5-1</u> 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>5-1</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                 |  |   |  |   |  |  |  |  |  |  |   |                                    |   |  |   |  |  |
| 22b. SIGNATURE<br>A. Shamir  |  |   |  | DEGREE<br>MD  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>5-2-80   |   |                                    |   |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ahmad SHAMIR  |  |   |  | 22e. ADDRESS<br>200 Ft. Meade Rd - Laurel, Md.  |  |  |  |  |  |  |   |                                    |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>May 5 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven                       |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring Mont Md.   |   |                                    |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Francis J. Collins   |  |   |  | ADDRESS<br>500 University Boulevard, W. Silver Spring, Md.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 5 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>D. McBrady   |   |                                    |   |  |   |  |  |



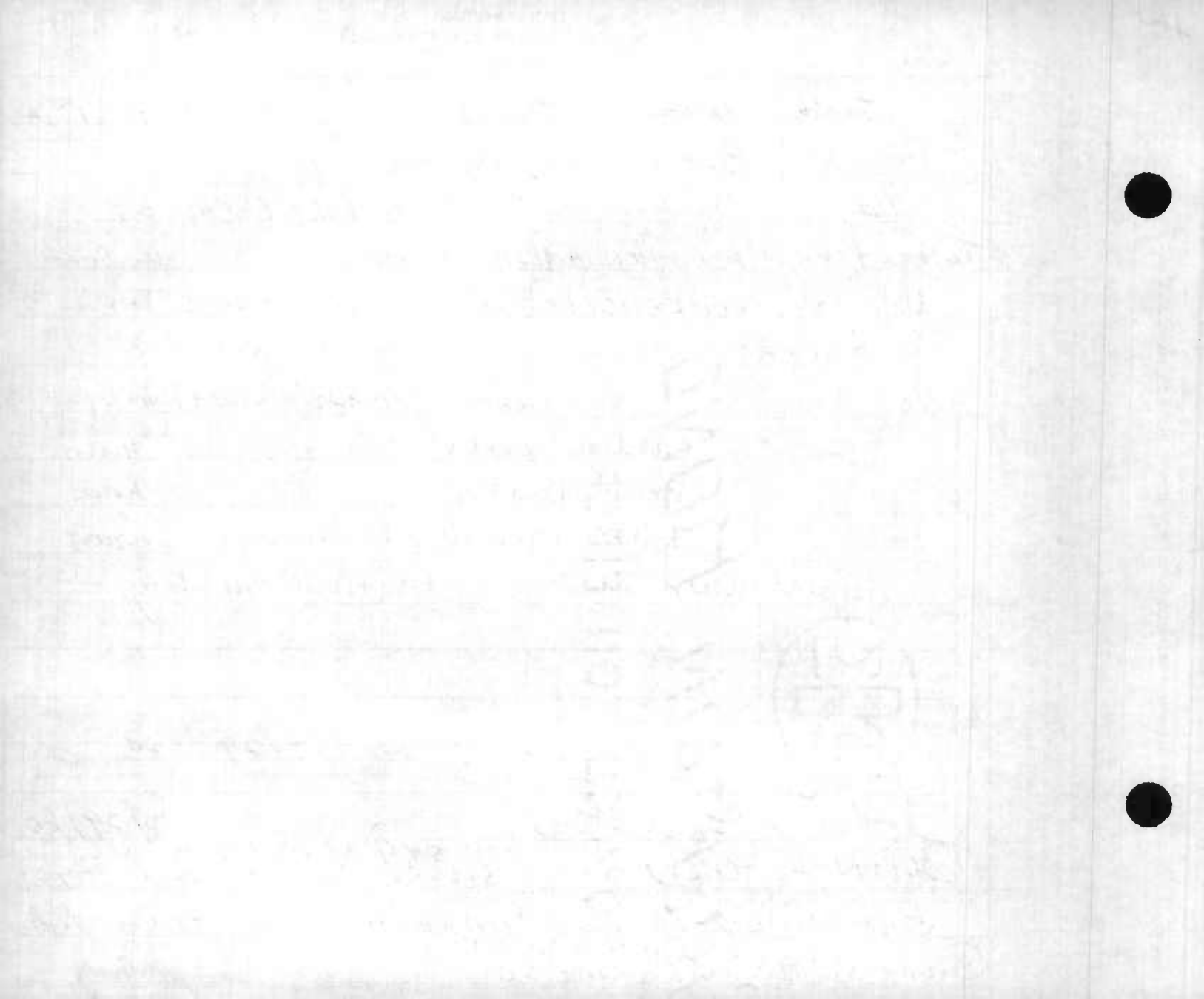


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. FOR<br>- STATE<br>REGISTRAR   |  | REG. NO. 80 13440   |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Janie Loretta Thomas</b>  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 29 80</b>   |  | 2b. HOUR<br><b>1:05 AM</b>   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 12, 1932</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                    |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hosp.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>U.S. Gov't</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Pr. Geo.</b>  |  | 13c. CITY OR TOWN<br><b>Beltsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>11316 EVANS TRAIL</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT CLARK</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JANIE BROOKS</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT<br>ADDRESS<br><b>James Thomas (husband) SAME AS #13</b>   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>431-</b> DUE TO OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Brain Death</b><br>DUE TO OR AS A CONSEQUENCE OF (c) <b>Intracerebral hemorrhage</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hours</b><br><b>hours</b><br><b>hours</b> |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Hypertension, Diabetes, Massive Obesity</b>  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>5/27 80</b> to <b>5/29 80</b> , that (2) (we) last saw the deceased alive on <b>5/28 80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>John L Ford M.D.</b>  |  |   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>5/29/80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN L FORD</b>  |  |   |  | 22e. ADDRESS<br><b>344 University Blvd W<br/>Silver Spring Md 20901</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>5-2-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. National Mem. Ar.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, Pr. Geo. Md.</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George R. Snowden</b>   |  |   |  | 24b. ADDRESS<br><b>246 N. WASH. ST.<br/>Rockville, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 4 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Larry McHenry</b>   |  |



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 12013 4 4 1  
**CERTIFICATE OF DEATH**

|  |  |  |   |   |   |   |   |  |  |  |
|--|--|--|---|---|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>CATHERINE LOUISE THOMPSON</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>5</b> Day <b>11</b> Year <b>80</b>  |   |   | 2b. HOUR<br><b>7:30 A</b> M   |   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>WHITE</b>                    |   | 5. DATE OF BIRTH<br><b>1-21-1892</b>  |   | 6. AGE (In years last birthday)<br><b>88</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.               |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Boston, Mass</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1006 STROUT STREET</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>                     |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |   | 13c. CITY OR TOWN<br><b>SILVER SPRING</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>1006 STROUT STREET</b> |  |  |  |
| 14. FATHER'S NAME<br>First <b>JOHN</b> Middle <b>CLEARY</b> Last <b>CATHERINE</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>CATHERINE</b> Middle <b>O'BRIEN</b> Last <b>CATHERINE</b>            |   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>   |   | 17. INFORMANT<br><b>MARY C. THOMPSON</b>  |   |   | Address<br><b>SAME AS 13 DAUGHTER</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4029</b> IMMEDIATE CAUSE (a) <b>HYPERTENSIVE ARTERIO SCLEROTIC CARDIO VASC DIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CHRONIC URINARY TRACT INFECTION</b>  |  |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?           |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 60</b> , to <b>May 11, 1980</b> , that (I) (we) last saw the deceased alive on <b>April 30, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Bernard A. Fitzgerald M.D.</b>  |  |  |   |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5-11-80</b>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>BERNARD A. FITZGERALD</b>   |  |  |   |   |   | 22e. ADDRESS<br><b>217 UNIVERSITY BLVD E, SILVER SPRING MD</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>5/14/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN CEMETERY</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>SILVER SPRING MONT MD.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>FRANCIS J. COLLINS</b>  |  |  |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAY 15 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John A. McCrady</b>                           |  |  |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |  |   |   |   |   |   |  |  |  |

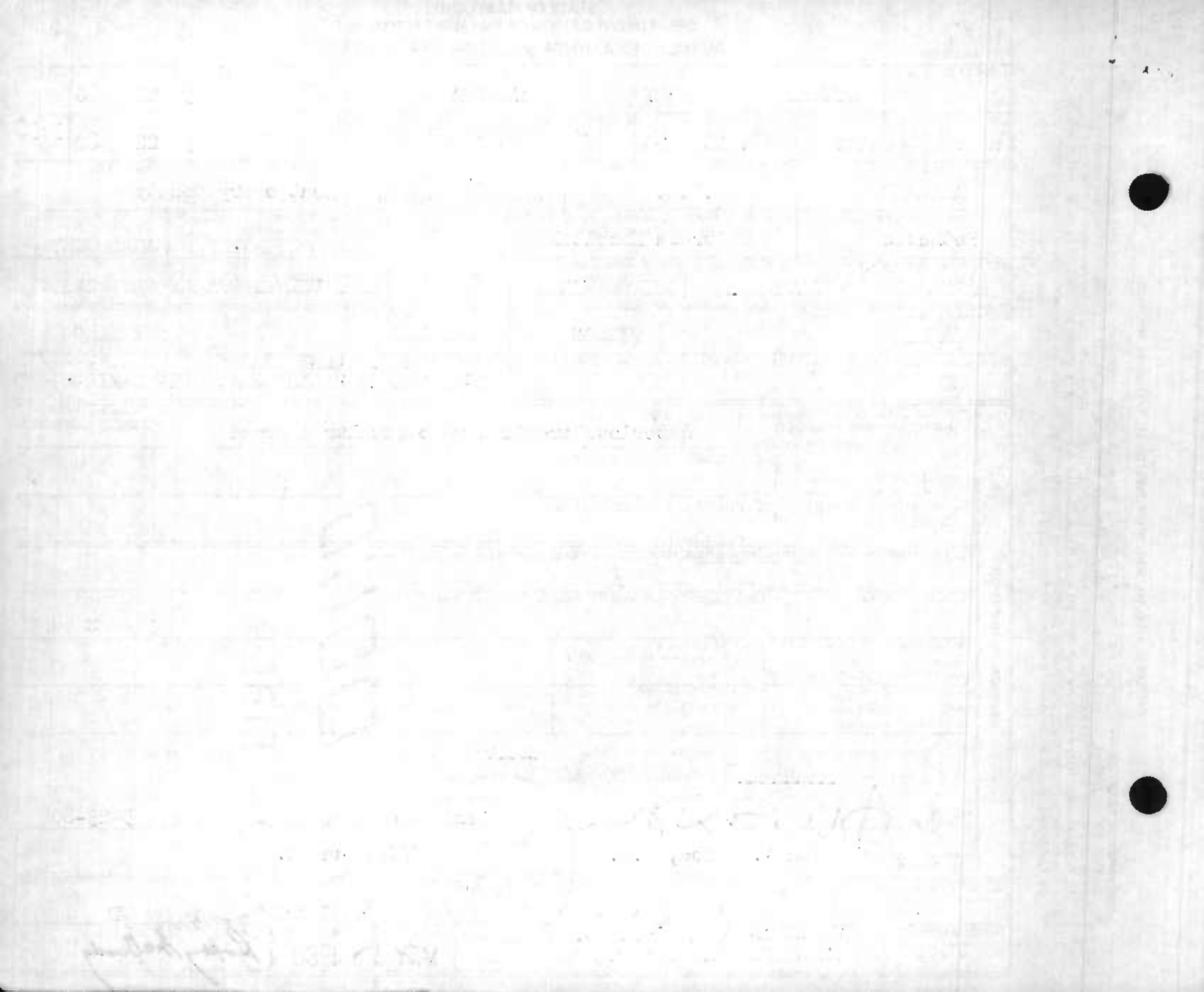
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLATE 15

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | REG. NO. 13442  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)                         |  |   |  |  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR  |  |
|  |  | FIRST  |  | MIDDLE  |  | LAST   |  | ESTIMATED   |  | MONTH DAY YEAR  |  |
|  |  | STUART   |  | BARRY   |  | TILSON   |  | <input checked="" type="checkbox"/>   |  | 5 22 19 80  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)  |  | 7. IF UNDER 1 YR.   |  | 8. IF UNDER 24 HRS.   |  |
| male   |  | white  |  | JAN. 25, 1935   |  | 45 YRS.  |  | MONTHS DAYS   |  | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | 9. NEVER MARRIED   |  | 10. WIDOWED   |  | 11. DIVORCED  |  |
| MARYLAND   |  | U.S.A.   |  | <input checked="" type="checkbox"/>                           |  | <input type="checkbox"/>                                 |  | <input type="checkbox"/>  |  | <input type="checkbox"/>  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | MD.   |  |
| Bethesda   |  | Suburban Hospital  |  | REAL ESTATE   |  | MANAGEMENT   |  | Montgomery County   |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS   |  |   |  |
| MARYLAND   |  | BALTIMORE  |  | OWINGS MILLS  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 2505 VELVET VALLEY WAY #21117   |  |   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                  |  | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  | 18. #21117  |  |
| SAMUEL   |  | SHIRLEY  |  | NO  |  |  |  | MRS. ILENE TILSON   |  |   |  |
|  |  | FEINBERG   |  | (IF YES, GIVE WAR OR DATES)                                   |  |  |  | 2505 VELVET VALLEY WAY, OWINGS MILLS, MD                                      |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART I DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |  |  |  |   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |  |  |   |  |  |  |   |  |   |  |
| (b)  |  |  |  |   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |   |  |   |  |
| (c)  |  |  |  |   |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |  |  |   |  | 20. AUTOPSY?  |  |
|  |  |  |  |   |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |
|  |  |  |  | P.M. 19   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |   |  |
|  |  |  |  |   |  |  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE   |  |  |  | TITLE (SPECIFY)   |  |  |  | DATE SIGNED   |  |   |  |
|  |  |  |  | M.D. Assistant  |  |  |  | 5-23-80   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |  |  | ADDRESS   |  |  |  |   |  |   |  |
| Ann M. Dixon, M.D.   |  |  |  | 111 Penn St.  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| BURIAL   |  |  |  | 5-25-80   |  | ARLINGTON-CHIZUK AMUNO                                   |  |   |  | BALTIMORE MD  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                 |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| SOL LEVINSON & BROS., INC.   |  |  |  | MAY 28 1980   |  |  |  |   |  |   |  |
| 6010 REISTERSTOWN RD., BALTO., MD 21215  |  |  |  |   |  |  |  |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Papers for the retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

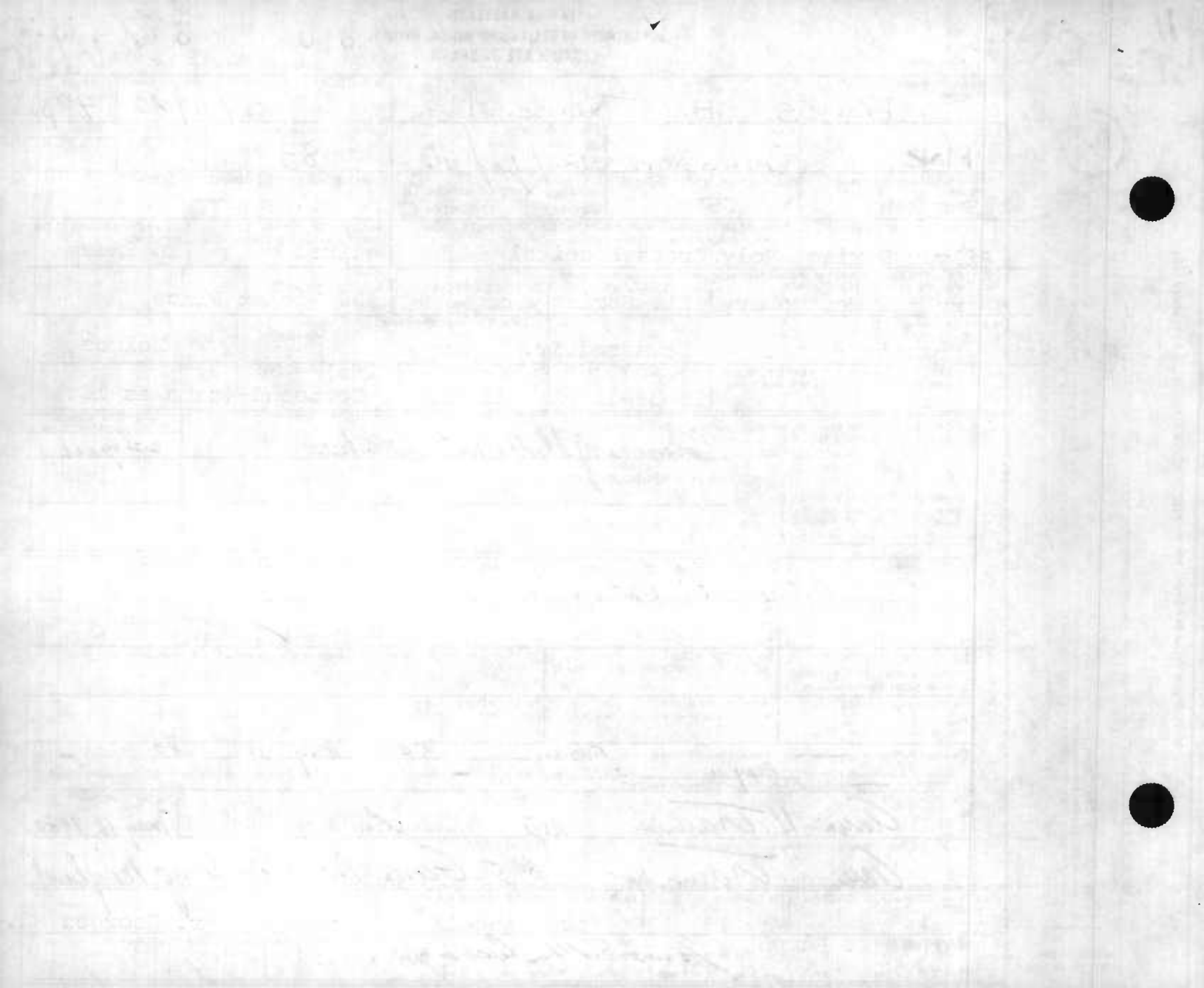
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 1 3 4 4 3   |  |
|---|--|---|--|---|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>Francis H. Townsend Jr.  |  |   |  | MONTH DAY YEAR<br>5/11/80   |  |
| 3 SEX<br>Male   |  |   |  | 2b. HOUR<br>9 <sup>15</sup> PM  |  |
| 4 RACE<br>Caucasian   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12/14/90                         |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                    |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  | 10 CITY OR TOWN OF DEATH<br>Silver Spring                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital  |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Engineer                          |  | 13a INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13a STATE<br>Maryland   |  | 13b COUNTY<br>Sil. Spring   |  | 13c STREET ADDRESS<br>806 Violet Place,   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Francis H. Townsend, Sr.   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Holmes           |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes  |  |
| 16b SOCIAL SECURITY NO<br>WW 1  |  | 17 INFORMANT (wife) ADDRESS<br>Lillian S. Townsend-(same as 13e)      |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of bladder with metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>22 years |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic heart disease</u>  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>February</u> , 19 <u>58</u> , to <u>May 11</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>May 11</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |   |  |
| 22b SIGNATURE<br><u>Claude H. Trautman</u>  |  | DEGREE<br>MD  |  | 22c DATE SIGNED<br>May 12 1980  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Claude H. Trautman MD</u>  |  | 22e ADDRESS<br><u>8915 Georgia Ave Silver Spring Maryland</u>         |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b DATE<br>May 15, 1980  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln   |  |
| 23d LOCATION<br>Brentwood Pr. Georges Md.   |  | 23e DATE REC'D. BY REGISTRAR<br>MAY 19 1980                           |  | 23f REGISTRAR'S SIGNATURE<br><u>Anthony McCreedy</u>  |  |
| 24 FUNERAL DIRECTOR<br><u>Warner E. Pumphrey, Inc.</u><br>8434 Ga. Ave., S.S. Md.   |  |   |  |   |  |







| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 0 1 3 4 4 4  |   |
|--|--|---|--|--|---|
| FOR<br>1 - STATE<br>REGISTRAR  |  |   |  | REG. NO.   |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Adele Minnie Tracy   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>May 21, 1980                           |  | 2b HOUR<br>3:53 PM  |
| 3 SEX<br>Female  | 4 RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 16 05   |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br>75 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Wash. DC  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.  |   |
| 10 CITY OR TOWN OF DEATH<br>SILVER SPRING  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOLY CROSS HOSPITAL |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE | 12b KIND OF BUSINESS OR INDUSTRY   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MARYLAND   |  |   | 13b CITY OR TOWN<br>MONTGOMERY   | 13c INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d STREET ADDRESS<br>8803 3RD AVENUE   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>CLARENCE E. REID  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CAROLINE R. HARRISON         |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>579-42-9218   |  | 17 INFORMANT<br>ADDRESS<br>LESLIE O. TRACY SAME AS 13 HUSBAND                                  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Liver failure<br>5733<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Cirrhosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Hepatitis |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 weeks<br>10 years<br>70 years   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Surgery  |  |   |  |  |   |
| 19a DATE OF OPERATION<br>5-2-80  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Blinding Varicosis   |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a I certify that (I) (this hospital) attended the deceased from 4-20 19 80 to 5-21 19 80, that (I) (we) lost<br>saw the deceased alive on 5-21 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |
| 22b SIGNATURE<br>Michael J. Sullivan M.D.  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c DATE SIGNED<br>5-21-80   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL J SULLIVAN M.D.  |  | 22e ADDRESS<br>18111 Prince Philip Dr Olney Md  |  |  |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  | 23b DATE<br>5/23/80  | 23c NAME OF CEMETERY OR CREMATORY<br>PARKLAWN CEMETERY  |  | 23d LOCATION<br>CITY OR TOWN<br>ROCKVILLE  | COUNTY STATE<br>MONT MD.  |
| 24 FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS  |  | 24b ADDRESS<br>500 UNIV. BLVD., W., SILVER SPRING, MD., 20901   |  | 25 DATE REC'D. BY REGISTRAR<br>MAY 23 1980   |   |
|  |  |   |  | 25b REGISTRAR'S SIGNATURE<br>[Signature]   |   |

RECEIVED  
JAN 12 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY  
FOR AGRICULTURAL MARKETING  
SERVICES

RECEIVED  
JAN 12 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY  
FOR AGRICULTURAL MARKETING  
SERVICES

72

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Body Released to Kirk E. Flury, M.D.  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be signed by a physician within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. STATE REGISTRAR

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
 Louise M Tuozzo

2a. DATE OF DEATH MONTH DAY YEAR  
 5 26 80

2b. HOUR  
 6:08AM

3 SEX  
 F

4 RACE  
 W

5 DATE OF BIRTH MONTH DAY YEAR  
 7 31 01

6 AGE (IN YEARS LAST BIRTHDAY)  
 78 YRS.

IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
 New Jersey

7b. CITIZEN OF WHAT COUNTRY?  
 USA

8 MARRIED ☐ NEVER MARRIED ☐  
 WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH  
 Montgomery MD.

10 CITY OR TOWN OF DEATH  
 Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
 Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
 housewife

12b. KIND OF BUSINESS OR INDUSTRY  
 home

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
 13a. STATE  
 Md

13b. COUNTY  
 Howard

13c. CITY OR TOWN  
 Laurel

13d. INSIDE CITY LIMITS?  
 YES ☐ NO ☒

13e. STREET ADDRESS  
 9150 Gross Avenue

14 FATHER'S NAME FIRST MIDDLE LAST  
 Dono Susini

15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
 Emma Andreoli

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
 no

16b. SOCIAL SECURITY NO.  
 577 40 5906

17 INFORMANT ADDRESS  
 Frank H. Tuozzo 9108 Hance Place, Laurel, Md

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory arrest  
 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)  
 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
 1hr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  
Abdominal aneurysm

19a. DATE OF OPERATION  
 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
 20a. AUTOPSY?  
 YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
 YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
 P.M. 19  
 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐  
 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  
 May 26 1980

22a. I certify that (I) (this hospital) attended the deceased from 5:30 AM 19 EO to 6:00 AM 19 EO, that (I) (we) lost saw the deceased alive on May 26 19 EO, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE  
 KIRK E. FLURY MD  
 DEGREE  
 ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐  
 22c. DATE SIGNED  
 5/26/80

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
 KIRK E. FLURY MD  
 22e. ADDRESS  
 94110 Old Georgetown Rd.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
 Burial  
 23b. DATE  
 May 28, 1980  
 23c. NAME OF CEMETERY OR CREMATORY  
 St Marys Cemetery  
 23d. LOCATION CITY OR TOWN COUNTY STATE  
 Laurel, Maryland

24. FUNERAL DIRECTOR NAME  
 [Signature]  
 ADDRESS  
 [Signature]  
 25a. DATE REC'D. BY REGISTRAR  
 JUN 2 1980  
 25b. REGISTRAR'S SIGNATURE  
 [Signature]



STATE OF MARYLAND

1- FOR  
STATE  
REGISTRAR

STATE OF MINNESOTA  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                       |  | THOMAS Francis  |  | LAST   |  | TYLER  |  | 2a. DATE KNOWN OF DEATH   |  | ESTIMATED  |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH                                   |  | 6. AGE (IN YEARS)                                |  | 7. IF UNDER 1 YR.   |  | 8. IF UNDER 24 HRS.                              |  | 9. DATE PRONOUNCED DEAD   |  | 10. HOUR   |  |
| MALE  |  | WHITE   |  | Sept. 4, 1904                                      |  | 75 YRS.  |  | MONTHS  |  | DAYS   |  | HOURS   |  | MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED   |  | NEVER MARRIED                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                      |  | 10. MONTH  |  | 11. DAY   |  | 12. YEAR   |  |
| Virginia  |  | USA   |  | WIDOWED  |  | DIVORCED   |  | MONTGOMERY COUNTY   |  | 5-9-   |  | 80  |  | 12:55 P.M.                                       |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK)               |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  | 13. CITY OR TOWN  |  | 14. STATE  |  | 15. COUNTY  |  | 16. CITY OR TOWN                                 |  |
| ROCKVILLE,  |  | Woods & Creek back of Nursing Home                          |  | Ret'd.   |  |  |  | Aldie   |  | Va.  |  | Loudoun   |  | Aldie  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                                  |  | 13d. INSIDE CITY LIMITS?                         |  | 13e. STREET ADDRESS   |  | 14. FATHER'S NAME                                |  | 15. MOTHER'S MAIDEN NAME  |  | 16. ADDRESS                                      |  |
| Va.   |  | Loudoun   |  | Aldie  |  | YES  |  | NO  |  | William Elmira Tyler                             |  | Mary Leith  |  | Leesburg, Va.                                    |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?                              |  | 17b. SOCIAL SECURITY NO.                                    |  | 17c. INFORMANT                                     |  | 17d. ADDRESS                                     |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  | 20. DATE OF OPERATION   |  | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED? |  |
| No  |  | 226-42-3982   |  | Thomas A. Tyler                                    |  | Leesburg, Va.                                    |  | 4292 Arteriosclerotic Cardiovascular Disease                              |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  | 20. DATE OF OPERATION                              |  | 21. CONDITION FOR WHICH OPERATION WAS PERFORMED? |  | 22. AUTOPSY?  |  | 23. YES  |  | 24. NO  |  | 25. DATE OF OPERATION                            |  |
| PART I DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF                     |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | (c)  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |
| 4292  |  | Arteriosclerotic Cardiovascular Disease                     |  |  |  |  |  |   |  |  |  |   |  |  |  |
| 26. EXTERNAL CAUSE WAS  |  | 27. TIME OF INJURY  |  | 28. HOW INJURY OCCURRED                            |  | 29. LOCATION                                     |  | 30. PLACE OF INJURY   |  | 31. LOCATION                                     |  | 32. DATE OF OPERATION   |  | 33. CONDITION FOR WHICH OPERATION WAS PERFORMED? |  |
| UNDERLYING OR CONTRIBUTING CAUSE OF DEATH                                 |  | HOUR MIN. MONTH DAY YEAR                                    |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 |  | CITY OR TOWN                                     |  | STREET  |  | COUNTY   |  | STATE   |  | 20. AUTOPSY?                                     |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION                                      |  | CITY OR TOWN                                     |  | COUNTY  |  | STATE  |  | 22. DATE OF OPERATION   |  | 23. CONDITION FOR WHICH OPERATION WAS PERFORMED? |  |
| WHILE AT WORK   |  | NOT WHILE AT WORK   |  |  |  |  |  |   |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on |  | Autopsy   |  | Inspection   |  | Inquiry  |  | and in my opinion   |  | 23. DATE OF OPERATION                            |  | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 25. AUTOPSY?                                     |  |
| death resulted from:  |  | Natural causes  |  | Accident   |  | Suicide  |  | Homicide  |  | Undetermined manner                              |  | 26. DATE OF OPERATION   |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED? |  |
| 26. DATE OF OPERATION   |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  | 28. AUTOPSY?                                       |  | 29. YES  |  | 30. NO  |  | 31. DATE OF OPERATION                            |  | 32. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 33. AUTOPSY?                                     |  |
| 28. DATE OF OPERATION   |  | 29. YES   |  | 30. NO   |  | 31. DATE OF OPERATION                            |  | 32. CONDITION FOR WHICH OPERATION WAS PERFORMED?                          |  | 33. AUTOPSY?                                     |  | 34. YES   |  | 35. NO   |  |
| 36. DATE OF OPERATION   |  | 37. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  | 38. AUTOPSY?                                       |  | 39. YES  |  | 40. NO  |  | 41. DATE OF OPERATION                            |  | 42. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 43. AUTOPSY?                                     |  |
| 44. DATE OF OPERATION   |  | 45. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  | 46. AUTOPSY?                                       |  | 47. YES  |  | 48. NO  |  | 49. DATE OF OPERATION                            |  | 50. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 51. AUTOPSY?                                     |  |
| 52. DATE OF OPERATION   |  | 53. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  | 54. AUTOPSY?                                       |  | 55. YES  |  | 56. NO  |  | 57. DATE OF OPERATION                            |  | 58. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 59. AUTOPSY?                                     |  |
| 60. DATE OF OPERATION   |  | 61. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  | 62. AUTOPSY?                                       |  | 63. YES  |  | 64. NO  |  | 65. DATE OF OPERATION                            |  | 66. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 67. AUTOPSY?                                     |  |
| 68. DATE OF OPERATION   |  | 69. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  | 70. AUTOPSY?                                       |  | 71. YES  |  | 72. NO  |  | 73. DATE OF OPERATION                            |  | 74. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 75. AUTOPSY?                                     |  |
| 76. DATE OF OPERATION   |  | 77. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  | 78. AUTOPSY?                                       |  | 79. YES  |  | 80. NO  |  | 81. DATE OF OPERATION                            |  | 82. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 83. AUTOPSY?                                     |  |
| 84. DATE OF OPERATION   |  | 85. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  | 86. AUTOPSY?                                       |  | 87. YES  |  | 88. NO  |  | 89. DATE OF OPERATION                            |  | 90. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 91. AUTOPSY?                                     |  |
| 92. DATE OF OPERATION   |  | 93. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  | 94. AUTOPSY?                                       |  | 95. YES  |  | 96. NO  |  | 97. DATE OF OPERATION                            |  | 98. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 99. AUTOPSY?                                     |  |
| 100. DATE OF OPERATION  |  | 101. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 102. AUTOPSY?                                      |  | 103. YES   |  | 104. NO   |  | 105. DATE OF OPERATION                           |  | 106. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 107. AUTOPSY?                                    |  |
| 108. DATE OF OPERATION  |  | 109. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 110. AUTOPSY?                                      |  | 111. YES   |  | 112. NO   |  | 113. DATE OF OPERATION                           |  | 114. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 115. AUTOPSY?                                    |  |
|   |  |   |  |  |  |  |  |   |  |  |  |   |  |  |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**NOTES TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER. **PENDING** IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **NOTES TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP\_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

